

Handbook for Delegates

TexMed 2018

TMA's Annual Meeting, Premier Educational Showcase, and Expo

Renew Your **Passion**

May 18-19 ★ JW Marriott San Antonio Hill Country Resort

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Texas Medical Association

Physicians Caring for Texans

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TexMed 2018 • May 18-19
JW Marriott San Antonio Hill Country Resort and Spa
23808 Resort Pkwy, San Antonio, TX 78261

WHAT TO DO WHEN

FRIDAY, May 18

6:30-7:30 am
TexMed Orientation: Level 2, Cibolo Ballroom 4
New members of the house meet for breakfast to review procedures.

7 am-6 pm
Registration: Level 2, Expo Hall

8 am
House of Delegates convenes: Level 2, Expo Hall

Immediately Following Opening Session
Reference committees meet in rooms on Level 2:
Financial & Organizational Affairs: Cibolo Ballroom 6
Medical Education & Health Care Quality: Cibolo Ballroom 8
Science & Public Health: Cibolo Ballroom 5
Socioeconomics: Cibolo Ballroom 7

Noon-1 pm
Free Networking Lunch: Level 2, Expo Hall

12:30-2 pm
Candidate Forum: Level 2, Cibolo Ballroom 8
Learn about the candidates running for TMA offices. Candidates will answer questions from the audience. Any member who attends will be entered into a drawing for a $500 Amazon gift card. *Must be present to win.*

3:30-5 pm *Sponsored by TMLT*
Opening General Session: Level 2, Expo Hall
Zubin Damania, MD (aka ZDoggMD)
Health Care, Remixed

5-6 pm *Sponsored by TMLT*
Welcome Reception: Level 2, Expo Hall

6-7 pm *Sponsored by TMAIT*
2018-19 TMA/TMAA Presidents' Reception:
Level 3, Bluebonnet

7-10:30 pm
TMA Foundation 25th Anniversary Annual Gala, Level 1, Nelson Wolff 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 19

6 am-1:30 pm
Registration: Level 2, Expo Hall

8:30 am
House of Delegates meets: Level 2, Expo Hall

12:30-1:30 pm
Lunch Available for Purchase: Level 2, Expo Hall

1:30-2:30 pm
Closing General Session: Level 2, Expo Hall
Gordon Hartman
You Only Are Disabled in and Environment That Makes You That Way

Caucus Meetings
Bexar County Medical Society
Saturday, 6:30 am, Level 2, Cibolo Ballroom 4

Dallas County Medical Society
Saturday, 6:30 am, Level 2, Cibolo Ballroom 8

Harris County Medical Society
Saturday, 6:30 am, Level 2, Cibolo Ballroom 7

Lone Star Caucus
Friday, 6:30 am, Level 3, Iris
Saturday, 6:30 am, Level 2, Cibolo Ballroom 6

Tarrant County Medical Society
Saturday, 6:30 am, Level 2, Cibolo Ballroom 10

Travis County Medical Society
Saturday, 6:30 am, Level 2, Cibolo Ballroom 2

Medical Student Section
Saturday, 6:30 am, Level 3, Alyssum

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 at the **Staff Work Room by the elevators on Level 2.**
- **Caucuses: Don't forget to pick up your packets!**
- **Reminder:** The *Handbook for Delegates* refers only to items being considered by the house. Reports and resolutions in the handbook and posted on the website are working drafts; they should not be considered as expressing Texas Medical Association views and programs until the house acts on them.
- **Clarification:** ONLY the **Recommendation portions** of reports and the **Resolve portions** of resolutions are considered by the House of Delegates; the Whereas portions are informational and explanatory.
- **Wi-Fi:** The free wireless network is TexMed2018 and the password is texmed.

REFERENCE COMMITTEES
May 2018

CHIEF TELLER
Faraz A. Khan, MD, Harris County Medical Society

CREDENTIALS
Leah H. Jacobson, MD, chair, Bexar County Medical Society
Christine A. Becker, MD, Dallas County Medical Society
Gina M. Jetter, MD, Smith County Medical Society
Judith L. Thompson, MD, Comal County Medical Society

FINANCIAL AND ORGANIZATIONAL AFFAIRS
Kathleen A. Cubine, DO, chair, Concho Valley County Medical Society
David J. Donahue, MD, Tarrant County Medical Society
David T. Lam, MD, Bexar County Medical Society
Hattie E. Henderson, MD, Harris County Medical Society
Mr. Stephen Haff (Student), Dallas County Medical Society
Thomas D. Kimbrough, MD, Galveston County Medical Society
Vani S. Vallabhaneni, MD, Travis County Medical Society

MEDICAL EDUCATION AND HEALTH CARE QUALITY
Deborah A. Fuller, MD, chair, Dallas County Medical Society
Ann E. Ranelle, MD, Tarrant County Medical Society
Belda Zamora, MD, Travis County Medical Society
Mammen A. Sam, MD, Brazoria County Medical Society
Manish Rungta, MD, Harris County Medical Society
Rajeev Suri, MD, Bexar County Medical Society
Samuel E. Mathis, MD (Resident), Galveston County Medical Society

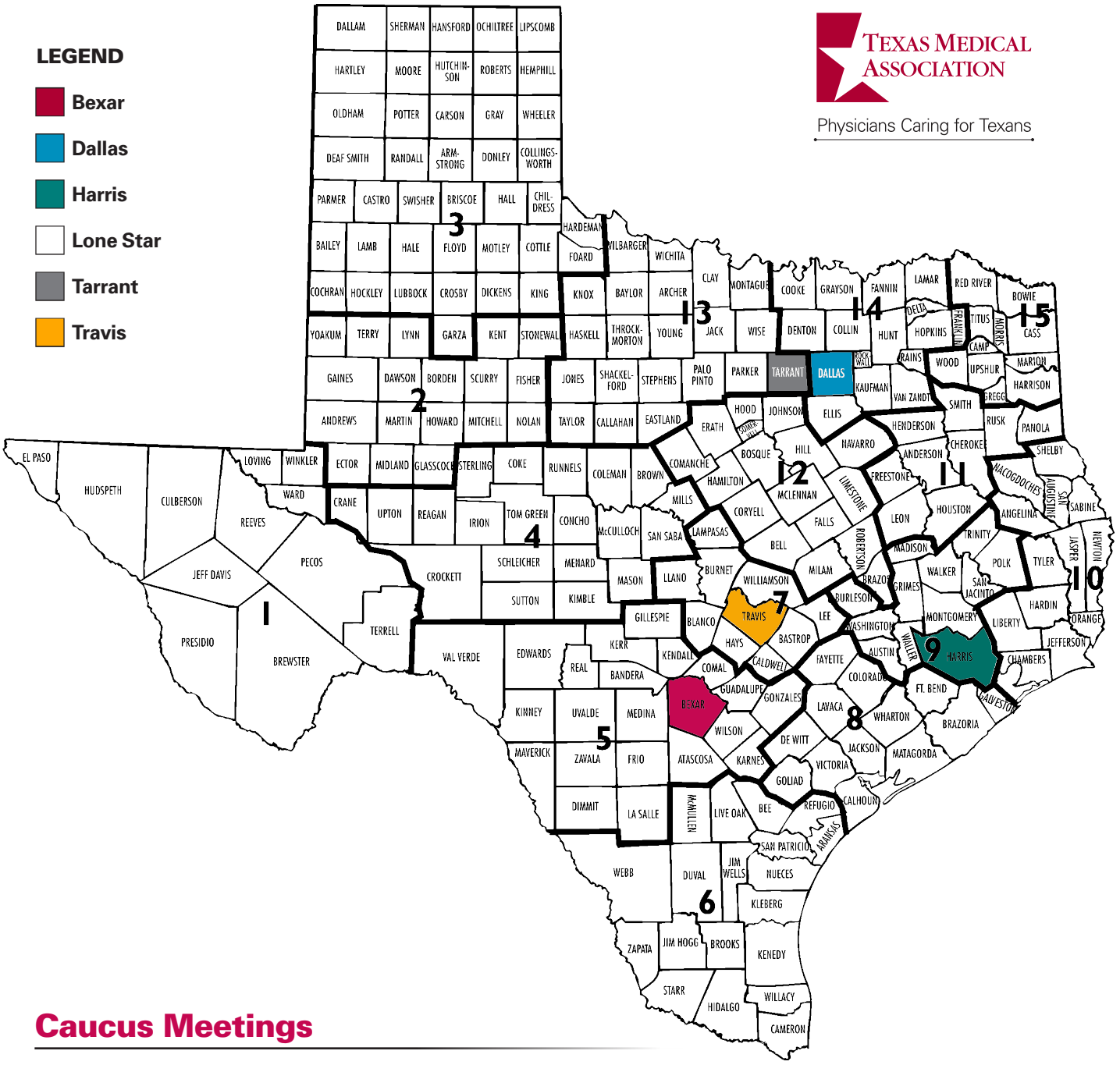
SCIENCE AND PUBLIC HEALTH
Tilden L. Childs III, MD, chair, Tarrant County Medical Society
Arathi A. Shah, MD, Dallas County Medical Society
Bindu Raju, MD, Bell County Medical Society
Mr. Donald B. Egan (Student), Bexar County Medical Society
Jeffrey S. Richards, MD, Galveston County Medical Society
Li-Yu H. Mitchell, MD, Smith County Medical Society
Susan N. Rossmann, MD, Harris County Medical Society

SOCIOECONOMICS
Nefertiti C. duPont, MD, chair, Montgomery County Medical Society
Amy F. Ho, MD, Dallas County Medical Society
Colby C. Evans, MD, Travis County Medical Society
Lesca C. Hadley, MD, Johnson County Medical Society
Terah C. Isaacson, MD, Harris County Medical Society
Vivian R. Hase, MD (Resident), Lubbock 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 2018 Texas Caucus Meetings



TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

Caucus Meetings

Bexar County Medical Society
Jayesh B. Shah, MD, Co-Chair
Michael A. Battista, MD, Co-Chair
Saturday, 6:30 am, Level 2, Cibolo Ballroom 4

Dallas County Medical Society
Mark Casanova, MD, Co-Chair
Leslie Secrest, MD, Co-Chair
Saturday, 6:30 am, Level 2, Cibolo Ballroom 8

Harris County Medical Society
Sherif Zaafran, MD, Chair
Bradford Patt, MD, Vice Chair
Saturday, 6:30 am, Level 2, Cibolo Ballroom 7

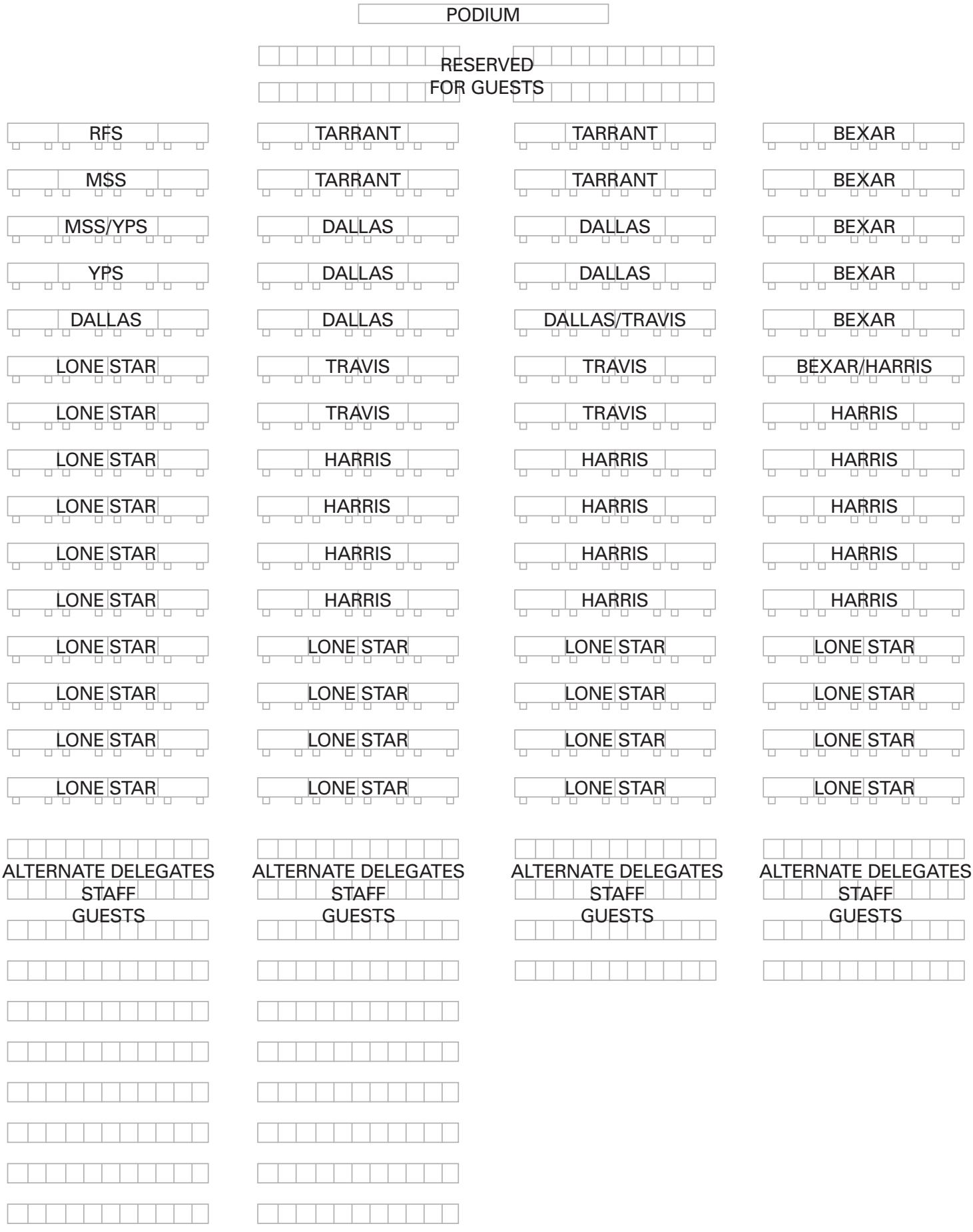
Lone Star
Brad Holland, MD, Co-Chair
Jed Grisel, MD, Co-Chair
Lenore DePagter, DO, Vice Chair
Friday, 6:30 am, Level 3, Iris
Saturday, 6:30 am, Level 2, Cibolo Ballroom 6

Tarrant County Medical Society
Robert J. Rogers, MD, Co-Chair
Gary Floyd, MD, Co-Chair
Saturday, 6:30 am, Level 2, Cibolo Ballroom 10

Travis County Medical Society
Tony R. Aventa, MD, Chair
Michelle Berger, MD, Vice Chair
Saturday, 6:30 am, Level 2, Cibolo Ballroom 2

304700.4/18

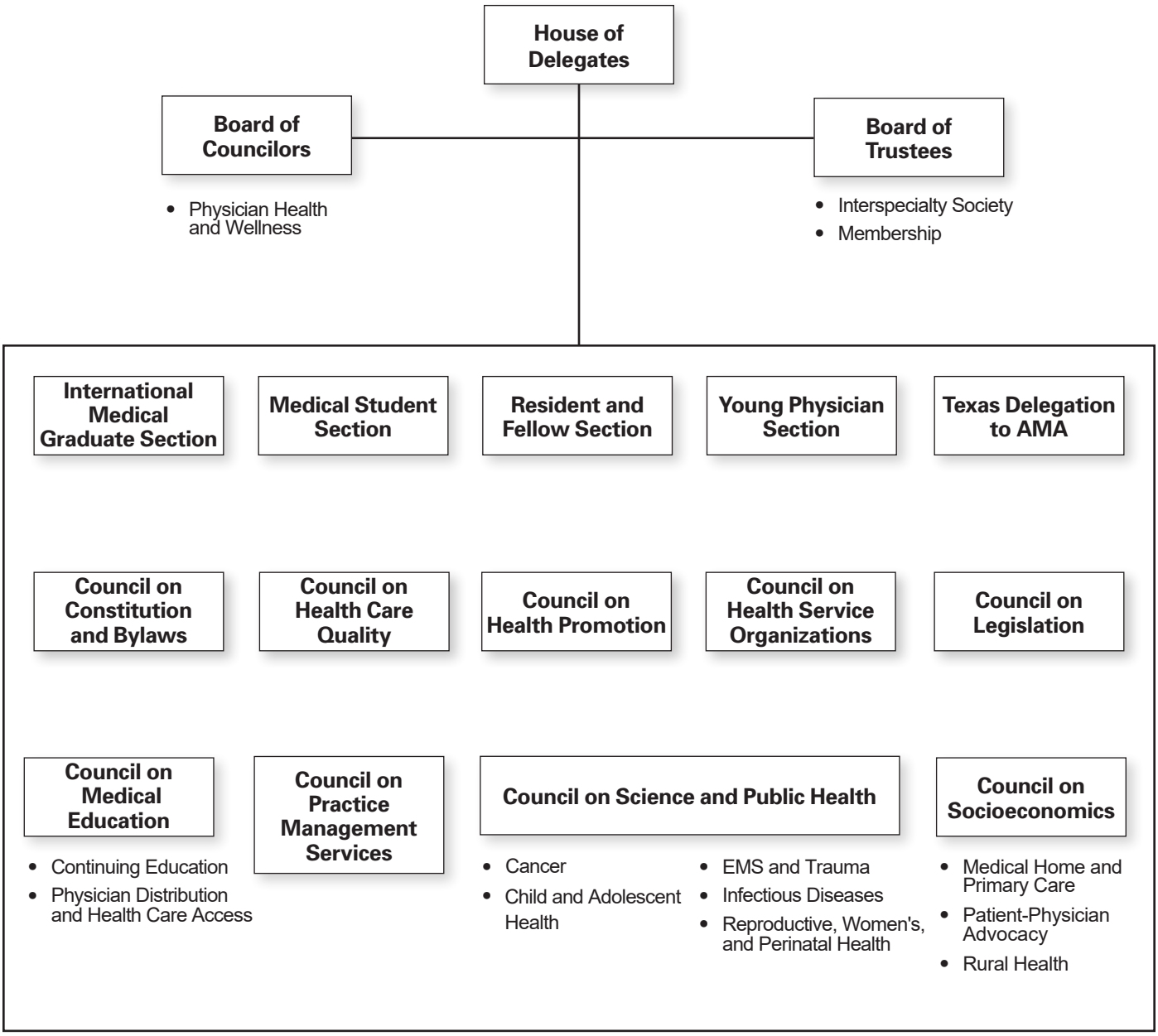
House of Delegates Seating Chart — Saturday Session 2018



TEXAS MEDICAL ASSOCIATION

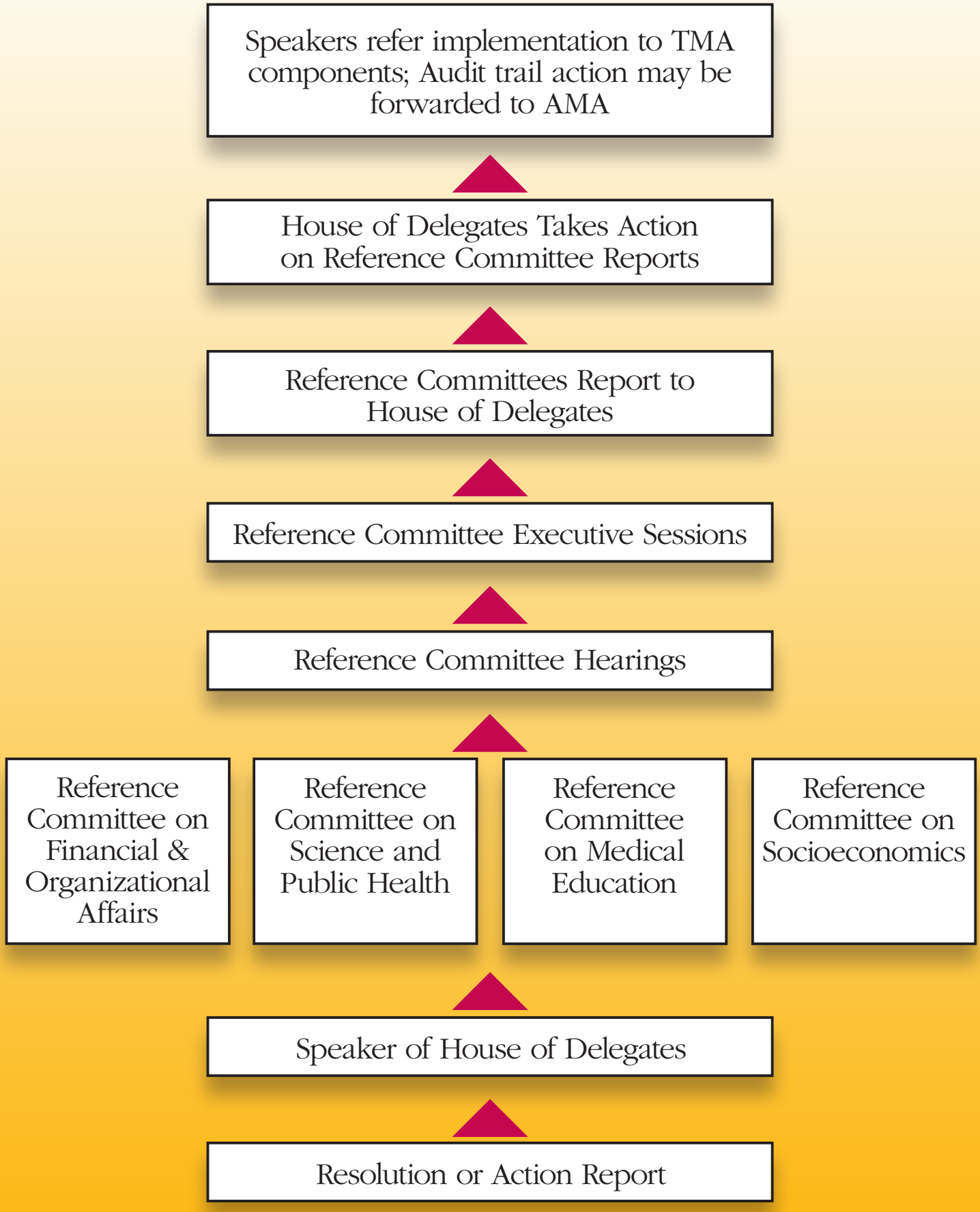
Physicians Caring for Texans

GOVERNANCE STRUCTURE

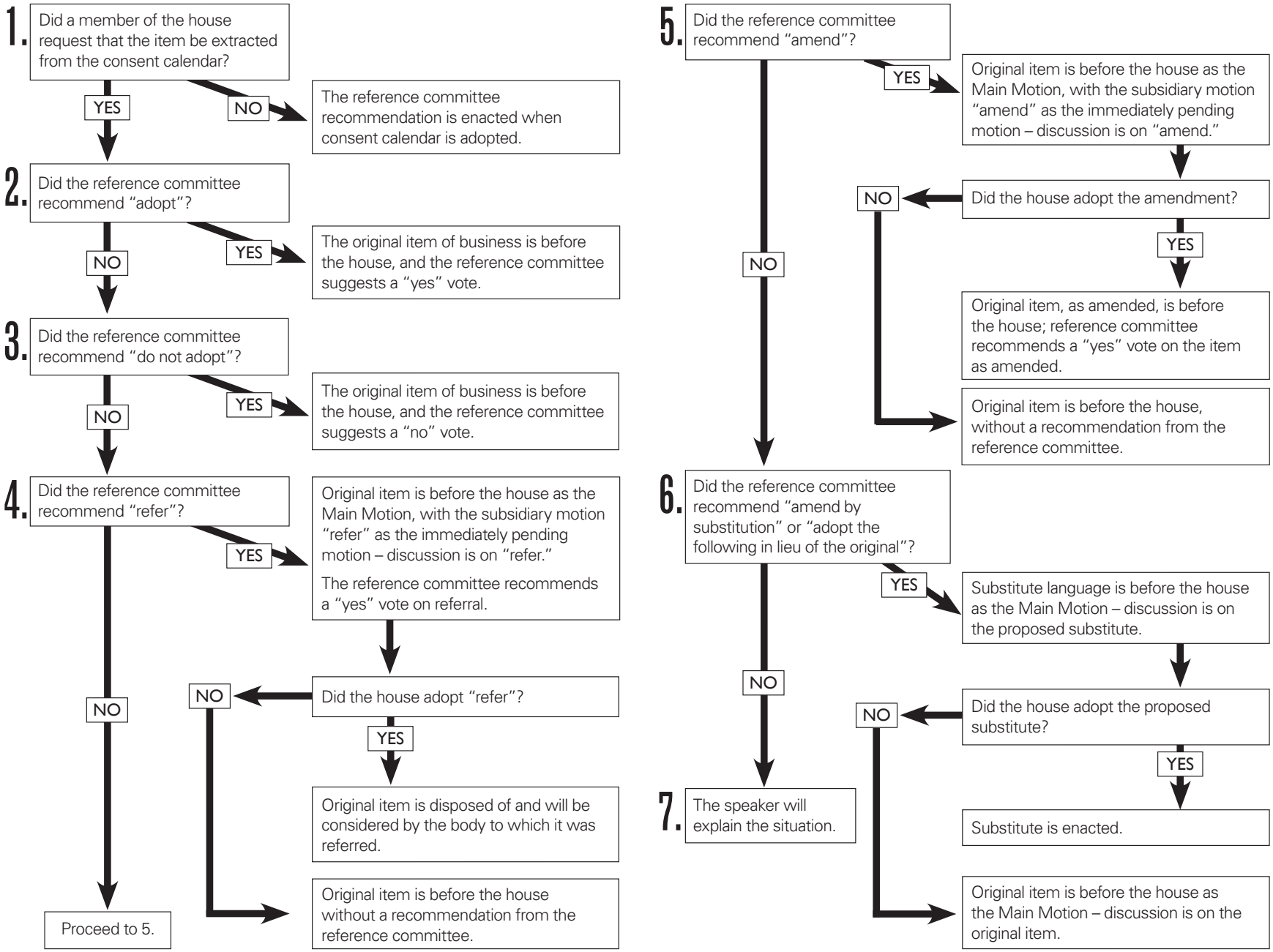


July 2016

Action Item Flow Chart



Flow Chart for Business Items



TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

PROCEDURE FOR BUSINESS ITEMS

July 2017

If There Is Objection to Consideration

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

Items Placed on Consent Calendar

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

If An Item is Not Extracted

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

If An Item Is Extracted

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

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

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

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

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

  If referral is defeated, the original item of business is now before the house, and the house may adopt it, defeat it, amend it, or take whatever other actions are proper to dispose of the original item. Since the reference committee recommended

referral, and referral was defeated, the reference committee now has no recommendation in its report on how to dispose of the original item, although the speaker may ask the reference committee chair to consult with the committee members and indicate the committee's recommendation, if the committee has one.

"Refer" may be "for study," or "for decision."

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

If an item is referred "for decision," the body to which it is referred is being given the full power of the house to act on that item, and may decide to adopt it, defeat it, amend it, refer it to still another body for study, or to dispose of it in any other way, and to implement whatever action is taken. Although not required, the body will report back to the house, explaining its findings and the actions performed.

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

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

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

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

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

  If "amend" is recommended, the full motion, resolution, or recommendation (or existing policy, if a change in existing policy is being proposed) is usually printed in full in the reference committee report, with words proposed for deletion indicated by "strike-through," and words proposed for insertion or addition indicated by underlining. This presentation assists delegates to visualize the final wording of the item of business, if the proposed amendment(s) are adopted.

- **"Substitute"** – If the reference committee recommends that the item of business "be amended by substitution," or that "the following be adopted in lieu of the original item," and the item is extracted from the consent calendar, the proposed substitute is before the house. The reference committee is suggesting that members should vote "yes" on the proposed substitute. If the house wishes, it may amend the proposed substitute before taking final action on it.

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

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

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

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

American Institute of Parliamentarians Standard Code of Parliamentary Procedure

Basic Rules Governing Motions

In order of precedence[1]

	Can interrupt?	Requires a second?	Debatable?	Amendable?	Vote required?	Applies to what other motions?	Can have what other motions applied to it?[5]	Renewable?
PRIVILEGED MOTIONS								
1. Adjourn	No	Yes	Yes[2]	Yes[2]	Majority	None	Amend, close debate, limit debate	Yes
2. Recess	No	Yes	Yes[2]	Yes[2]	Majority	None	Amend, close debate, limit debate	Yes[6]
3. Question of privilege	Yes	No	No	No	None	None	None	Yes
SUBSIDIARY MOTIONS								
4. Table	No	Yes	No	No	2/3	Main motion	None	No
5. Close debate	No	Yes	No	No	2/3	Debatable motions	None	Yes
6. Limit or extend debate	No	Yes	Yes[2]	Yes[2]	2/3	Debatable motions	Amend, close debate	Yes[6]
7. Postpone to a certain time	No	Yes	Yes[2]	Yes[2]	Majority	Main motion	Amend, close debate, limit debate	Yes[6]
8. Refer to committee	No	Yes	Yes[2]	Yes[2]	Majority	Main motion	Amend, close debate, limit debate	Yes[6]
9. Amend	No	Yes	Yes[3]	Yes	Majority	Rewordable motions	Amend, close debate, limit debate	No[6]
MAIN MOTIONS								
10. a. The main motion	No	Yes	Yes	Yes	Majority	None	Subsidiary	No
b. Specific main motions								
Adopt in-lieu-of	No	Yes	Yes	Yes	Majority	None	Subsidiary	No
Amend a previous action	No	Yes	Yes	Yes	Same Vote	Adopted main motion	Subsidiary	No
Ratify	No	Yes	Yes	Yes	Same Vote	Adopted main motion	Subsidiary	No
Recall from committee	No	Yes	Yes[2]	No	Majority	Referred main motion	Close debate, limit debate	No
Reconsider	Yes[4]	Yes	Yes[2]	No	Majority	Vote on main motion	Close debate, limit debate	No
Rescind	No	Yes	Yes	No	Same Vote	Adopted main motion	Subsidiary, except amend	No

Incidental Motions

No order of precedence

MOTIONS								
Appeal	Yes	Yes	Yes	No	Majority[7]	Ruling of chair	Close debate, limit debate	No
Suspend the rules	No	Yes	No	No	2/3	Procedural rules	None	Yes
Consider informally	No	Yes	No	No	Majority	Main motion or subject	None	Yes
REQUESTS								
Point of order	Yes	No	No	No	None	Procedural error	None	No
Inquiries	Yes	No	No	No	None	All motions	None	No
Withdraw a motion	Yes	No	No	No	None[8]	All motions	None	No
Division of question	No	No	No	No	None[8]	Main motion	None	No
Division of assembly	Yes	No	No	No	None[8]	Indecisive vote	None	No

1. Motions are in order only if no motion higher on the list is pending. Thus if a motion to close debate is pending, a motion to amend would be out of order; but a motion to recess would be in order, since it outranks the pending motion.
2. Restricted.
3. Is not debatable when applied to an undebatable motion.
4. A member may interrupt the proceedings but not a speaker.
5. Withdraw may be applied to all motions.
6. Renewable at the discretion of the presiding officer.
7. A tie or majority vote sustains the ruling of the presiding officer; a majority vote in the negative reverses the ruling.
8. If decided by the assembly, by motion, requires a majority vote to adopt.

*The Chief Purposes of Motions**

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

TMA follows the American Institute of Parliamentarians Standard Code of Parliamentary Procedure

CONFLICTS OF INTEREST POLICY OF THE TEXAS MEDICAL ASSOCIATION

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

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

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

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

EXPLANATION OF CONFLICTS OF INTEREST

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

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

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

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

Activities That Might Cause Conflict of Interest

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

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

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

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

Conflicts of Interest — Scenario 1

A TMA member serves as a TMA representative in a group that includes physicians and nonphysicians. For the group to meet its ultimate goal, it must choose a vendor of certain services. At the time of the selection process, the TMA member has

a significant financial interest in one of the proposed vendors that is not widely known among the group's members. The TMA Conflicts of Interest Policy would apply as follows:

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

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

Conflicts of Interest — Scenario 2

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

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

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

Conflicts of Interest — Scenario 3

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

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

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

Conflicts of Interest — Scenario 4

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

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

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

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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May 2018

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Jerjis Jamil Denno, MD, San Antonio
Carla B. Devenport, DO, Fort Worth
Walter Esmond Dickinson, MD, Albuquerque
Robert F. Dornon, MD, Bellville
Clarence O. Dube, MD, Houston
Burdett S. Dunbar, MD, Houston
Brian Abraham Ellman, MD, Dallas
Emmett Mohammed Essin, Jr., MD, Sherman
Robert J. Fairchild, MD, Pasadena
Jose Luis Fernandez, MD, San Antonio
Jordan W. Finkelstein, MD, University Park
Adrian E. Flatt, MD, Dallas
Robert Lee Fordtran, III, MD, Corpus Christi
Paul T. Forth, Jr., MD, Houston
Daniel Willett Foster, MD, Dallas
Robert R. Franklin, MD, Katy
Lillian M. Fuller, MD, Houston
Michael Fushille, MD
Howell R. Gaddy, Jr., MD, Tyler
Lawrence O. Gahagan, MD, Dallas
William G. Gamel, MD, Austin
Richard Earl Garrett, MD, Abilene
Jeremy Matthew Gaspar, DO, Fort Worth
Robert R. Gatti, MD, Hideaway
Frederick Stewart Geist, MD, Dallas
John R. Gerdes, MD, Temple
Raymond R. Gibbons, MD, Dallas
Leonard Paul Gietz, MD, Victoria
Francis A. Giglio, MD, Beaumont
Mary Goessler, MD, McKinney
Bradford Maurice Goff, MD, New York
Lindsay A. Gragowski, MD, Wolfforth
Audrey Lynn Graham, MD, Dallas
George E. Granville, MD, Houston
Ghent Graves, Jr., MD, Ingram
Jack A. Gray, MD, Arlington
Jerry W. Green, DO, Dallas
Theodore H. Greiner, MD, Dallas
Sheryl Ann Grove, MD, Georgetown
Michael B. Gruber, MD, Dallas
Gerhard Fritz Gruschkus, MD, Dallas
William G. Guerriero, MD, Houston
Robert E. Gulde, MD, Amarillo
Jack P. Gunter, MD, Dallas
Lillian P. Gustavson, MD, Houston
Marshall Earl Hamilton, MD, Brady
Henry H. Hand, MD, Washington
William Lee Hand, MD, El Paso
Gerald R. Harrington, MD, San Antonio
William M. Head, MD, Fort Worth
Walter E. Herbst, MD, Victoria
James J. Herman, MD, Lubbock
Charles A. Hill, MD, Houston
Welton E. Hill, MD, Bellville
William R. Holder, MD, Baytown
Alfonso Hudson Holguin, MD, San Antonio
Jill D. Holland, MD, Kilgore
Barry L. Horwitz, MD, Houston
James Duane Houston, MD
Jed L. Howard, MD, Houston
Donald S. Huge, MD, Houston
Warren Hansell Hunt, III, MD, Longview
David M. Hunter, MD, Colorado Springs
Eric R. Hurd, MD, Dallas
Lee Aubry Hutton, MD, Dickinson
Huma I. Iftikhar, MD, Houston

William Insull, Jr., MD, Houston
Vaidyanath Iyer, MD, Spring
Edward Nasif Jabalie, MD, El Paso
Daniel Jackson, MD, Houston
Barry R. Jacobs, MD, Denton
Milton Sherl Jacobs, MD, San Antonio
Robert A. Johnston, Jr., MD, Houston
Russell James Johnston, MD, Nacogdoches
Lisa Day Jones, MD, Austin
Roy E. Joyner, MD, Houston
Jack Lynwood Judson, MD, Fort Worth
William S. Kafoglis, MD, Katy
George H. Kakaska, MD, Farmersville
James Griffin Keatts, MD
Martin H. Keeler, MD, Houston
Michael V. Kelly, II, MD, Spring
William Wendell Kempe, MD, Desoto
Michael S. Kessler, MD, Sugar Land
Chong W. Kim, MD, Addison
Shirley Jane Kindberg-Coln, MD, Dallas
Daniel H. Kinzie, IV, MD, Graford
Kenneth John Krajewski, MD
Donald E. Krause, MD, Dallas
Otto A. Krueger, MD, San Antonio
Justin Paul Le Vasseur, MD, Wichita Falls
Abbe A. Ledbetter, Jr., MD, Houston
Dennis L. Lehman, MD, Joshua
O. Scott Leinart, Jr., MD, Hideaway
Wade Hampton Lewis, MD, San Antonio
Deena Ray Liles, MD, San Antonio
Edward Anthony Liske, Jr., MD, Frisco
David A. Love, MD, Houston
Herbert M. Loyd, MD, Abilene
Percy Edgar Luecke, Jr., MD, Dallas
Brock D. Lutz, MD, Tyler
Andrew Ernest MacMahon, MD, Houston
Gerald W. Maness, MD, Houston
James Frederic Marks, MD, Dallas
William R. Masters, DO, Houston
Robert L. McClendon, MD, Sugar Land
W. Curtis McGinley, MD, N. Richland Hills
Grant R. McKeever, MD, Bellville
Luis O. Mendoza, MD, Laredo
Lowell Stephen Miller, MD, Nada
Carl V. Mitten, DO, Fort Worth
Ajit Kumar Modak, MD, Cedar Park
Guillermo A. Montoya, MD, Bellaire
Rodney C. Moore, MD, Dallas
Edward H. Morris, MD, Aransas Pass
James Merrill Motes, MD, Corpus Christi
Royce Allan Mull, MD, Terrell
Suhasini R.J. Basu Nadesan, MD, Amarillo
Leigh Z. Naftolin, MD
Luther Sullivan Nelson, MD
Robert Carroll Newberry, MD, Dallas
Milton H. Nirken, MD, Austin
Anita L. O'Neil, MD, Red Lodge
Lyle C. Olson, DO, Gulfito
Kirit K. Pandya, MD, Sugar Land
Joyce Ann Pardue, MD, Shepherdstown
David Norfleet Parker, MD, Corpus Christi
Edward L. Patten, MD, Houston
Manuel C. Pecana, MD, Irving
Jesus Mario Perches, MD, Natalia
Don W. Pranke, MD, Houston
Mario E. Ramirez, MD, Dripping Springs
Remberto Rangel, MD, Seabrook
Martin P. Rappaport, MD, Conroe
Kurt Walter Rathjen, MD, Dallas
Gerald Ratinov, MD, Houston
Mason Charles Reddix, MD, San Antonio
Napoleon Brannon Riddle, MD, Longview
Richard Russell Ritter, MD, San Antonio
Shannon M. Rivenes, MD, Sugar Land
Francisco J. Rodriguez, MD, San Antonio
Marjorie F. Roper, MD, Bullard
Spencer Andrews Rowland, MD, San Antonio
James Otis Royder, DO, Lancaster
Gary Walter Schabacker, MD, El Paso
Ted Charles Scott, MD, Sugar Land
Stephen G. Seifert, MD, San Angelo
George W. Shaw, MD, Tyler
Jaspreet S. Sidhu, MD, Dallas
Louis Marshall Sloan, MD, Dallas
John F. Smart, MD, El Paso
Howard Lee Smith, MD, Marlin
Hubert L. Smith, Jr., MD, Houston
Joe Ed Smith, MD, Athens
Richard G. Smith, MD, Houston
Charles G. Spivey, Jr., MD, Helotes
Bevan E. Steadman, MD, Tyler
Bobby Ray Stewart, MD, Rowlett
James Richard Stewart, MD, San Antonio
Dennis Keith Stone, MD, Dallas
Joseph Edward Stuteville, MD, Houston
Emery Lowell Suderman, DO
William Everett Swan, Jr., MD, Corpus Christi
Antonio D. Talusan, MD, Lubbock
Richard Goan Tannerya, MD, Houston
Donald Franklin Terry, MD, Wichita Falls
Lewis Reyers Thompson, Jr., MD, Garland
Nathan H. Topek, MD, Georgetown
Robert S. Toth, MD, Montgomery
Edmund F. Touma, DO, Bullard
Christopher J. Trauth, MD, Abilene
Billy Bob Trotter, MD, Abilene
Francesco Turturro, MD, Houston
Joyce Ullom, MD, Lubbock
Ray R. Valdez, MD, Houston
John R. Vorhies, Jr., MD, Dallas
Philip Arthur Wales, MD, Lockhart
John Roscoe Ware, MD, Dallas
Buford A. Wells, MD, Pearland
Alvin S. Wexler, MD, Houston
Jerry Allen White, MD, Kingwood
David Ashby Whiting, MD, Dallas
Douglas Elliott Whitley, MD, Tyler
Roy D. Wilson, MD, Ben Wheeler
Grover Kenneth Womack, MD, Aledo
Charles V. Wright, Jr., MD, Amarillo
Valerie K. Wright, MD, Waco
Ronald L. Young, MD, Houston
Theodore F. Zipf, MD, Garden City

HOUSE OF DELEGATES COMPOSITION
May 2018

County society delegates 370

Ex officio-voting positions 154

- President 1
- President-Elect 1
- Immediate Past President 1
- Secretary/Treasurer 1
- Speaker 1
- Vice Speaker 1
- At-large members of the Board of Trustees 12
- Councilors 15
- Texas Delegation to the AMA 33
- Members of the Council on Legislation 15
- Chairs of all other councils 8
- International Medical Graduate Section delegate 1
- Young Physician Section delegates 5
- Resident and Fellow Section delegates 3
- Medical Student Section delegates 12
- Specialty society delegates 24
- Past Presidents *20

Ex officio nonvoting positions:

- TEXPAC Chair 1
- Delegates emeritus of the Texas Delegation to the AMA 3

Total voting membership *462

- Delegates 370
- Voting Ex officio 154
- Less those holding multiple voting positions 42

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

As Of: 4-20-2018

MEMBERS OF THE HOUSE OF DELEGATES AND VICE COUNCILORS
May 2018

KEY

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

SPECIALTY CODES

Code	Description
A	Allergy
ACA	Adult Cardiothoracic Anesthesiology
ADL	Pediatric Adolescent Medicine
ADM	Addiction Medicine
ADP	Addiction Psychiatry
AHF	Advanced Heart Failure & Transplant Cardiology
AI	Allergy & Immunology
ALI	Allergy/Immunology, Clin & Lab Immunology
AM	Aerospace Medicine
AMF	Family Practice, Adolescent Medicine
AMI	Internal Medicine, Adolescent Medicine
AN	Anesthesiology
APM	Anesthesiology, Pain Medicine
AR	Radiology, Abdominal
AS	Surgery, Abdominal
ASO	Advanced Surgical Oncology
ATP	Pathology, Anatomic
BBK	Pathology, Blood Bank/Transfusion Med.
BIN	Brain Injury Medicine
BIP	Brain Injury Medicine
CAP	Child Abuse Pediatrics
CBG	Genetics, Clinical Biochemical
CCA	Anesthesiology, Critical Care Medicine
CCE	Critical Care Medicine (Emergency Medicine)
CCG	Genetics, Clinical Cytogenetic
CCM	Internal Medicine, Critical Care Medicine
CCP	Pediatric Critical Care
CCS	Surgery, Critical Care
CD	Cardiovascular Disease
CFS	Surgery, Craniofacial
CG	Genetics, Clinical
CHD	Adult Congenital Heart Disease
CHN	Neurology, Child
CHP	Psychiatry, Child & Adolescent
CHS	Congenital Cardiac Surgery (Thoracic Surgery)
CIM	Clinical Informatics (Preventive Medicine)
CIP	Clinical Informatics
CLP	Pathology, Clinical
CMG	Genetics, Clinical Molecular
CN	Neurology, Clinical Neurophysiology
CPP	Pediatrics/Psychiatry/Child & Adolescent Psychiatry
CRS	Colon & Rectal Surgery
CS	Cosmetic Surgery
CTR	Cardiothoracic Radiology
D	Dermatology
DBP	Pediatrics Developmental-Behavioral
DDL	Dermatological Immun., Clin & Lab Immun.
DIA	Diabetes
DMP	Dermatopathology
DR	Radiology, Diagnostic
DS	Surgery, Dermatologic
EFM	Emergency Medicine/Family Medicine
EM	Emergency Medicine
EMP	Emergency Medicine Pediatrics
EMS	Emergency Medical Services
END	Endo, Diabetes & Metabolism
ENR	Endovascular Surgical Neuroradiology
EP	Epidemiology
EPL	Epilepsy
ES	Endovascular Surgical Neuroradiology
ESM	Emergency Medicine, Sports Medicine
ESN	Endovascular Surgical Neuroradiology

ETX	Emergency Medicine, Medical Toxicology
FM	Family Medicine
FMP	Family Medicine/Preventive Medicine
FOP	Pathology, Forensic
FPG	Family Practice, Geriatric Medicine
FPP	Psychiatry/Family Medicine
FPR	Female Pelvic Medicine & Reconstructive Surgery, OB/Gyn
FPS	Plastic Surgery, Facial Plastic
FSM	Family Practice, Sports Medicine
GE	Gastroenterology
GO	Gynecological Oncology
GP	General Practice
GPM	General Preventive Medicine
GS	Surgery, General
GYN	Gynecology
HEM	Hematology
HEP	Hepatology
HMP	Pathology, Hematology
HNS	Surgery, Head & Neck
HO	Hematology/Oncology
HOS	Hospitalist
HPA	Hospice & Palliative Medicine (Anesthesiology)
HPD	Hospice & Palliative Medicine (Radiology)
HPE	Hospice & Palliative Medicine (Emergency Medicine)
HPF	Hospice & Palliative Medicine (Family Medicine)
HPI	Hospice & Palliative Medicine (Internal Medicine)
HPM	Hospice & Palliative Medicine
HPN	Hospice & Palliative Medicine (Psychiatry & Neurology)
HPO	Hospice & Palliative Medicine (Obstetrics & Gynecology)
HPP	Hospice & Palliative Medicine (Pediatrics)
HPR	Hospice & Palliative Medicine (Physical Medicine & Rehabilitation)
HPS	Hospice & Palliative Medicine (Surgery)
HS	Surgery, Hand
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
MSR	Radiology, Musculoskeletal
N	Neurology
NC	Nuclear Cardiology
NDN	Psychiatry & Neurology, Neurodevelopmental Disabilities
NDP	Pediatrics Neurodevelopmental Disabilities
NEP	Nephrology
NM	Nuclear Medicine
NMN	Neuromuscular Medicine
NMP	Neuromuscular Medicine (Physical Medicine & Rehabilitation)
NNM	Neurology/Nuclear Medicine
NO	Otology/Neurotology
NP	Pathology, Neuropathology
NPM	Neonatal-Perinatal Medicine
NPR	Neurology Physicial 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
PDC	Pediatric Cardiology
PDD	Pediatric Dermatology
PDE	Pediatric Endocrinology
PDI	Pediatric Infectious Diseases
PDM	Pediatrics/Dermatology
PDO	Pediatric Otolaryngology
PDP	Pediatric Pulmonology
PDR	Radiology, Pediatric
PDS	Pediatric Surgery
PDT	Pediatric Medical Toxicology
PE	Emergency Medicine, Pediatric Emergency Medicine
PEM	Pediatric Emergency Medicine
PFP	Psychiatry, Forensic
PG	Pediatric Gastroenterology
PHL	Phlebology
PHM	Pharmaceutical Medicine
PHO	Pediatric Hematology-Oncology
PHP	Public Health & General Preventive Medicine
PLI	Pediatric Clin & Lab Immunology
PLM	Palliative Medicine
PM	Physical Medicine & Rehabilitation
PME	Pain Management
PMG	Pediatrics/Medical Genetics
PMM	Pain Medicine
PMN	Pain Medicine, Neurology
PMP	Pain Medicine Physical Medicine and Rehabilitation
PN	Pediatric Nephrology
PO	Pediatric Ophthalmology
PP	Pediatric Pathology
PPM	Pediatrics Physical Medicine and Rehabilitation
PPN	Pain Medicine (Psychiatry)
PPR	Pediatric Rheumatology
PRD	Procedural Dermatology
PRO	Proctology
PRS	Physical Medicine & Rehab, Sports Medicine
PS	Plastic Surgery
PSH	Plastic Surgery w/in Head & Neck
PSM	Pediatric Sports Medicine
PSO	Plastic Surgery Within The Head & Neck (Otolaryngology)
PSP	Plastic Surgery Within The Head & Neck (Plastic Surgery)
PTH	Pathology, Anatomical/Clinical
PTP	Pediatric Transplant Hepatology
PTX	Preventive Medicine, Medical Toxicology
PUD	Pulmonary Diseases
PYA	Psychoanalysis
PYG	Psychiatry, Geriatrics
PYM	Psychosomatic Medicine
PYN	Psychiatry/Neurology
R	Radiology
REN	Reproductive Endocrinology
RHU	Rheumatology
RNR	Neuroradiology
RO	Radiation Oncology
RP	Radiological Physics
RPM	Pediatric Rehabilitation Medicine
SCI	Spinal Cord Injury
SMA	Sleep Medicine (Anesthesiology)
SME	Sleep Medicine
SMI	Sleep Medicine (Internal Medicine)
SMN	Sleep Medicine (Psychiatry & Neurology)
SMO	Sleep Medicine (Otolaryngology)
SMP	Sleep Medicine (Pediatrics)
SO	Surgical Oncology
SP	Selective Pathology
THP	Transplant Hepatology (Internal Medicine)
TRS	Surgery, Trauma
TS	Surgery, Thoracic
TTS	Surgery, Transplant
U	Urology
UCM	Urgent Care Medicine
UM	Undersea & Hyperbaric Medicine
UME	Undersea & Hyperbaric Medicine (Emergency Medicine)
UP	Pediatric Urology
UPR	Female Pelvic Medicine, Urology
US	Unspecified
VIR	Radiology, Vascular & Interventional
VM	Vascular Medicine
VN	Neurology, Vascular
VS	Surgery, Vascular

Members of the House of Delegates and Vice Councilors

Name	City	Specialty	District	County Medical Society	Codes
Jason L. Acevedo, MD	Abilene	OTO	13th	Big Country	A, A-YPS
Madhureeta Achari, MD	Houston	N	9th	Harris	A
Manuel L. Acosta, MD	El Paso	GS	1st	El Paso	D
Rehan Ahmed, MD	Houston	OPH	9th	Harris	A
Audrey E. Ahuero, MD	Houston	OPH	9th	Harris	D
Charlotte M. Akor, MD	Abilene	PO	13th	Big Country	A
Drew Wilson Alexander, MD	Dallas	ADL	14th	Dallas	D
Jessica A. Alexander, MD	Houston	AN	9th	Harris	D
Raymond T. Alexander, MD	Houston	IM	9th	Harris	D
Ronda E. Alexander, MD	Houston	OTO	9th	Harris	D
Asif Ali, MD	Houston	CD	9th	Harris	A
Asra Ali, MD	Houston	D	9th	Harris	A
Bohn D. Allen, MD	Arlington	GS	13th	Tarrant	P
Lisa E. Allen, DO	Tyler	FM	11th	Smith	A
Paul M. Allison, MD	Houston	PTH	9th	Harris	D
Valarie Lee Allman, MD	Marshall	IM	15th	Harrison	D
Anna M. Allred, MD	Katy	AN	9th	Harris	A, D-YPS
Ogechika Karl Alozie, MD	El Paso	IM	1st	El Paso	D
Michael A. Altman, MD	Houston	FM	9th	Harris	Ex
Alexander J. Alvarez, MD	Austin	AI	7th	Travis	A
Jaya S. Amaram-Davila, MD	Pearland	IM	9th	Harris	A
Mario Rudy Anzaldua, MD	Mission	FM	6th	Hidalgo-Starr	Ex
Robert L. Arkus, MD	Houston	GE	9th	Harris	D
John R. Asbury, MD	Temple	PD	12th	Bell	VC
Tony R. Aventa, MD	Austin	IM	7th	Travis	D
Sarah S. Avery, MD	Austin	R	7th	Travis	SSA
Kimberly C. Avila Edwards, MD	Austin	PD	7th	Travis	D
Folahan Kolawole Ayoola, MD	Highland Village	GS	14th	Denton	A
Syed K. Azeemuddin, MD	Houston	PHO	9th	Harris	D
John Kerry Badlissi, MD	Nederland	IM	10th	Jefferson	A
Charles W. Bailey Jr., MD	Austin	PS	7th	Travis	P
Susan Rudd Bailey, MD	Fort Worth	AI	13th	Tarrant	Ex, P
Ralph F. Baine, MD	Fort Worth	EM	13th	Tarrant	A
Kulvinder S. Bajwa, MD	Houston	GS	9th	Harris	A
Rajaram Bala, MD	San Antonio	PS	5th	Bexar	D
Zachary E. Ballenger, MD	Lubbock	DR	3rd	Lubbock	A
Mauricio Bandeira-Teixeira, MD	Alice	GS	6th	Brooks-Duval-Jim Wells	D
Tracey Ann Banks, MD	McKinney	OBG	14th	Collin-Fannin	A
Brian Edward Barkley, DO	Woodway	PD	12th	McLennan	A
Elaine Mowinski Barron, MD	El Paso	IM	1st	El Paso	D, VC
Martin Basaldua, MD	Kingwood	FM	9th	Harris	D
Janette K. Bateman, MD	Pearland	FM	9th	Harris	D
Michael A. Battista, MD	San Antonio	NPM	5th	Bexar	D
Alan C. Baum, MD	Houston	OPH	9th	Harris	P
Joane G. Baumer, MD	Fort Worth	FM	13th	Tarrant	D
Christine Ann Becker, MD	Dallas	IM	14th	Dallas	D
Benjamin Wallace Beckert, MD	Beaumont	PS	10th	Jefferson	D
H. S. Bedi, MD	Houston	NPM	9th	Harris	D
Donald A. Behr, MD	Graham	GS	13th	Young	D

As of: 4/20/2018

Name	City	Specialty	District	County Medical Society	Codes
Ira Bell III, MD	Austin	MDM	7th	Travis	D
Brent B. Belvin, MD	Allen	PM	14th	Collin-Fannin	D
Luis Manuel Benavides, MD	Laredo	FM	6th	Webb-Zapata-Jim Hogg	D
Michelle A. Berger, MD	Austin	OPH	7th	Travis	D, Ex, SSA
Phil H. Berry Jr., MD	Dallas	ORS	14th	Dallas	P
Jessica A. Best, MD	Austin	EM	7th	Travis	A-YPS
Louise H. Bethea, MD	Spring	A	9th	Harris	SSD
Brittany Lynn Bickelhaupt, MD	San Antonio	PM	5th	Bexar	A
Vijay K. Bindingnavele, MD	Corpus Christi	PS	6th	Nueces	A
Justin M. Bishop, MD	Dallas	PM	14th	Dallas	D, Ex
Scott E. Blattman, MD	Woodway	FM	12th	McLennan	D
Maya B. Bledsoe, MD	Austin	END	7th	Travis	D
Gary Bloomgarden, MD	Dallas	NS	14th	Dallas	A
Susan K. Blue, MD	Fort Worth	N	13th	Tarrant	A
Brian T. Boies, MD	San Antonio	AN	5th	Bexar	A
James Byron Boone III, MD	El Paso	AN	1st	El Paso	A
Sue Scher Bornstein, MD	Dallas	IM	14th	Dallas	Ex
Sarojini G. Bose, MD	McAllen	PD	6th	Hidalgo-Starr	D
Lindsay K. Botsford, MD	Sugar Land	FM	9th	Harris	D, SSA
Keith A. Bourgeois, MD	Houston	OPH	9th	Harris	Ex
Thomas A. Bowman, MD	Lubbock	NPM	3rd	Lubbock	D
Richard N. Bradley, MD	Houston	EM	9th	Harris	D
Jim Bob Brame, MD	Eldorado	FM	4th	Concho Valley	P
Bodo Brauer, MD	Beaumont	FM	10th	Jefferson	D
Robert W. Brobst Jr., MD	Plano	OTO	14th	Collin-Fannin	A
Peter Andrew Brokish, MD	McKinney	EM	14th	Collin-Fannin	A
Stephen L. Brotherton, MD	Fort Worth	ORS	13th	Tarrant	P
Brian M. Bruel, MD	Houston	PME	9th	Harris	D
Adam J. Bruggeman, MD	San Antonio	ORS	5th	Bexar	SSD
Edward D. Buckingham, MD	Austin	FPS	7th	Travis	D
Lucy A. Buencamino, MD	Houston	IM	9th	Harris	D
Bradly Bundrant, MD, MPH	Ballinger	EM	4th	Concho Valley	D
Lu Ann L. Bundrant, MD	Austin	IM	7th	Travis	A
Ryan A. Burden	Lubbock		3rd	Lubbock	A, D-MSS
James Ray Burleson, MD	Snyder	FM	2nd	Colorado Basin	D
Dianna M. Burns-Banks, MD	San Antonio	PD	5th	Bexar	A
Brad G. Butler, MD	Abilene	AN	13th	Big Country	Ex
Gerald R. Callas, MD	Beaumont	AN	10th	Jefferson	Ex
Luis H. Camacho, MD	Houston	HO	9th	Harris	A
Carlos Javier Cardenas, MD	Edinburg	GE	6th	Hidalgo-Starr	Ex
John T. Carlo, MD	Dallas	PHP	14th	Dallas	Ex
Adam C. Carter, MD	Dallas	PM	14th	Dallas	D
Kimberly Carter, MD	Austin	OBG	7th	Travis	SSA
Mark A. Casanova, MD	Dallas	IM	14th	Dallas	Ex
William Hampton Caudill, MD	Dallas	EM	14th	Dallas	D
Vella Victoria Chancellor, MD	Mansfield	GYN	14th	Dallas	D
Kristie R. Chandler, MD	The Woodlands	PD	9th	Montgomery	A
Samuel J. Chantilis, MD	Dallas	REN	14th	Dallas	D
Jessica Clifton Charest, MD	Plainview	OBG	3rd	Hale-Floyd-Briscoe	D
Sudipta K. Chaudhuri, DO	Houston	IM	9th	Harris	D

Name	City	Specialty	District	County Medical Society	Codes
Naidu K. Chekuru, MD	Lubbock	PUD	3rd	Lubbock	A
Esther J. Cheung-Phillips, MD	Austin	OTO	7th	Travis	D
Tilden L. Childs III, MD	Fort Worth	DR	13th	Tarrant	SSD
Elizabeth L. Chmelik, MD	Austin	FM	7th	Travis	D
Vineet Choudhry, MD	Austin	GS	7th	Travis	A
Christopher Sung Jin Chun, MD	Dallas	APM	14th	Dallas	D
Wendy M. Chung, MD, MSPH	Dallas	PDI	14th	Dallas	D
Ellia Ciammaichella, DO	Houston	PM	9th	Harris	A
Josie Ann Cigarroa, MD	San Antonio	P	5th	Bexar	D
Chelsea I. Clinton, MD	San Antonio	RHU	5th	Bexar	D
Scott W. Clitheroe, MD	Austin	IM	7th	Travis	A
John David Cluley, MD	Austin	GE	7th	Tri-County	A
Brett L. Cochrum, MD	Fort Worth	FM	13th	Tarrant	A
Gates B. Colbert, MD	Dallas	NEP	14th	Dallas	D-YPS
Donald R. Collins Jr., MD	Houston	PS	9th	Harris	A
Shanna Marie Combs, MD	Fort Worth	OBG	13th	Tarrant	A
Tamyra Y. Comeaux, MD	Cypress	OBG	9th	Harris	A
Ronald Lynn Cook, DO	Lubbock	FM	3rd	Lubbock	D
Stacey L. Coombes, MD	Houston	OBG	9th	Harris	A
Jack Locardi Cortese, MD	Corpus Christi	NEP	6th	Nueces	D
Rafael Francisco Coutin, MD	Corpus Christi	CD	6th	Nueces	A
Charles E. Cowles Jr., MD	Pasadena	AN	9th	Harris	D, SSA
James S. Cox, MD	Fort Worth	EM	13th	Tarrant	A
Steven M. Croft, MD	Houston	N	9th	Harris	D
Theresa V. Crouch, MD	Arlington	DR	13th	Tarrant	A
Patrick D. Crowley	Arlington		13th	Tarrant	Ex
Kathleen A. Cubine, DO	San Angelo	END	4th	Concho Valley	A
Douglas W. Curran, MD	Athens	FM	11th	Henderson	Ex
Ramzi S. Dakour, MD	Beaumont	FM	10th	Jefferson	A
Anh Q. Dang, MD	Houston	AN	9th	Harris	A
Lilette E. Daumas-Britsch, MD	Houston	GP	9th	Harris	A
Peter Davenport, MD	Marble Falls	FM	7th	Burnet-Lampasas	D
Antonia M. Davidson, MD	Austin	IM	7th	Travis	A
Christian Davidson	Dallas		14th	Dallas	A-MSS
Alison L. Days, MD, MPH	El Paso	PD	1st	El Paso	A
Louise N. De Boer, MD	Odessa	IM	2nd	Ector	D
Carrie E. De Moor, MD	Frisco	EM	14th	Collin-Fannin	D, Ex
Miguel De Valdenebro, MD	Dallas	AN	13th	Tarrant	A
Richard W. Demmler, MD	Seabrook	FPG	9th	Harris	D
Lenore C. DePagter, DO, MBA	McAllen	IM	6th	Hidalgo-Starr	D
Shashi K. Dharma, MD	Irving	OPH	14th	Dallas	D
Neha V. Dhudshia, MD	Plano	IM	14th	Collin-Fannin	D
Thiendella Diagne, MD	Edinburg	OBG	6th	Hidalgo-Starr	A
Marlene Diaz, MD	Plano	OBG	14th	Collin-Fannin	D
Sandra Dee Dickerson, MD	Lubbock	GS	3rd	Lubbock	D
Robert Lee Dickey Jr., MD	Abilene	ORS	13th	Big Country	D
Kyle F. Dickson, MD, MBA	Bellaire	ORS	9th	Harris	D
Rakhi C. Dimino, MD	Houston	OBG	9th	Harris	D
Emma L. Dishner, MD	Houston	ID	9th	Harris	A
Sharmila D. Dissanaike, MD	Lubbock	GS	3rd	Lubbock	A

Name	City	Specialty	District	County Medical Society	Codes
Dayna G. Diven, MD	Austin	D	7th	Travis	A
Steven C. Diven, MD	Austin	NPM	7th	Travis	A
David J. Donahue, MD	Fort Worth	NSP	13th	Tarrant	D
Larry C. Driver, MD	Houston	PMM	9th	Harris	SSA
Swapan Dubey, MD	Sugar Land	EM	9th	Harris	D
Jack E. DuBose, MD	Lubbock	FM	3rd	Lubbock	D
Nefertiti C. Dupont, MD	Spring	OBG	9th	Montgomery	D
Suresh Venkayya Dutta, MD	Helotes	RO	5th	Bexar	D
Betty Jo Edwards, MD	Houston	OBG	9th	Harris	D
John D. Edwards, MD	San Antonio	OTO	5th	Bexar	D
Donald Bryan Egan	San Antonio		5th	Bexar	D-MSS
Lisa L. Ehrlich, MD	Houston	IM	9th	Harris	D
Mark Carroll Eidson, MD	Weatherford	FM	13th	Parker	D
William Alex Elfarr, MD	Athens	U	11th	Henderson	A
Tina P. Elkins, MD	Athens	OTO	11th	Henderson	D
Robert Harold Emmick Jr., MD	Austin	EM	7th	Travis	A, Ex
Michael G. Enger, MD	Arlington	FM	13th	Tarrant	A
Andres S. Enriquez, MD	El Paso	FM	1st	El Paso	A
Terry Fuller Eska, MD	Gonzales	IM	5th	Gonzales	A
James R. Eskew, MD	Austin	OTO	7th	Travis	D, Ex
Ciara Marie Espinoza	Houston		3rd	Lubbock	A-MSS
Sandra Esquivel, MD	Weslaco	GS	6th	Hidalgo-Starr	D, VC
Rebecca Lee Euwer, MD	Dallas	D	14th	Dallas	SSA
Colby C. Evans, MD	Austin	D	7th	Travis	A
Walter Francis Evans II, MD	Dallas	OBG	14th	Dallas	D
Christopher S. Ewin, MD	Fort Worth	FM	13th	Tarrant	A
Antonio Falcon, MD	Rio Grande City	FM	6th	Hidalgo-Starr	A
Heather M. Falvo, MD	Austin	IM	7th	Travis	A
Angelina Farella, MD	Webster	PD	9th	Harris	D
Martin W. Fielder, MD	Sulphur Springs	OBG	14th	Hopkins-Franklin	D
Troy T. Fiesinger, MD	Sugar Land	FM	9th	Harris	A, SSD
Lauren Cortell Fine, MD	Dallas	EM	14th	Dallas	D
George H. Fisher Jr., MD	Corpus Christi	OTO	6th	Nueces	D
Diana L. Fite, MD	Magnolia	EM	9th	Harris	Ex
Juan Francisco Fitz, MD	Lubbock	EM	3rd	Lubbock	D
David C. Fleeger, MD	Austin	CRS	7th	Travis	Ex
William H. Fleming III, MD	Houston	N	9th	Harris	Ex, P
Jason R. Fletcher, DO	Little Elm	EM	14th	Collin-Fannin	A
John Gerard Flores, MD	Carrollton	IM	14th	Denton	Ex
Mark J. Florian, MD	Bryan	IM	12th	Brazos-Robertson	D
Gary W. Floyd, MD	Keller	PD	13th	Tarrant	Ex
John Robert Floyd II, MD	San Antonio	NS	5th	Bexar	SSA
Juliana M. Fort, MD	Dallas	CHP	14th	Dallas	D
Nancy Thorne Foster, MD	Austin	IM	7th	Travis	D
Roshni K. Foster, MD, PhD	Lewisville	AI	14th	Denton	A
Josephine Rebecca Fowler, MD	Arlington	FM	13th	Tarrant	D
Raymond L. Fowler, MD	Dallas	EM	14th	Dallas	D
Lewis E. Foxhall, MD	Houston	FM	9th	Harris	D
Sheldon Ygnacio Freeberg, MD	Tyler	CD	11th	Smith	VC
Deborah Anne Fuller, MD	Dallas	OBG	14th	Dallas	D
Gregory M. Fuller, MD	Keller	FM	13th	Tarrant	Ex

Name	City	Specialty	District	County Medical Society	Codes
Etai Funk, MD	Houston	OTO	9th	Harris	A
Jessica L. Gale	San Antonio		5th	Bexar	D-MSS
Meera Gangadharan, MD	Corpus Christi	PD	6th	Nueces	A
A. Tomas Garcia III, MD	Houston	CD	9th	Harris	EMER, P
Angela Fulgham Gardner, MD	Grapevine	EM	14th	Dallas	D
Lloyd Marshall Garland, MD	Lubbock	NS	3rd	Lubbock	D
Arthur Garson Jr., MD	Houston	PD	9th	Harris	D
Aimee C. Garza, MD	Dallas	CN	14th	Collin-Fannin	D
Martin Garza, MD	Edinburg	PD	6th	Hidalgo-Starr	D
Harold V. Gaskill, MD	San Antonio	MDM	5th	Bexar	D
Cameron H. Gates, DO	Austin	R	7th	Tri-County	A
Stephen D. Gelfond, MD	San Antonio	P	5th	Bexar	D
Clare N. Gentry, MD	Houston	ID	9th	Harris	A
Marina C. George, MD	Houston	IM	9th	Harris	D
Vimal T. George, MD	Austin	FM	7th	Travis	D
Laura Faye Gephart, MD, MBA	McAllen	OBG	6th	Hidalgo-Starr	D
Bernard M. Gerber, MD	Bellaire	P	9th	Harris	D
Bobby J. Gerich Jr.	Dickinson		9th	Harris	D-MSS
Albert Lee Gest, DO	Corpus Christi	EM	6th	Nueces	D
Noel M. Giesecke, MD	Houston	AN	9th	Harris	A
John T. Gill, MD	Dallas	ORS	14th	Dallas	Ex
P. Ridgway Gilmer Jr., MD	Houston	PTH	9th	Harris	A
William S. Gilmer, MD	Houston	N	9th	Harris	Ex
John Russell Gilmore, MD	Dallas	OTO	14th	Dallas	D
Alan P. Glombicki, MD	Houston	GE	9th	Harris	D
Lisa Jennifer Go, MD	Temple	IM	12th	Bell	D
Mary Josephine Godinich, MD	Texas City	NEP	8th	Galveston	D
Sara Goel, DO	Houston	PM	9th	Harris	A
Roland A. Goertz, MD, MBA	Waco	FM	12th	McLennan	A, Ex
Alice Kim Gong, MD	San Antonio	NPM	5th	Bexar	D
Mark Stewert Gonzalez, MD	McAllen	CD	6th	Hidalgo-Starr	D
Victor Hugo Gonzalez, MD	McAllen	OPH	6th	Hidalgo-Starr	A, Ex
Victor Gonzalez, MD	Dallas	GS	14th	Dallas	D
Erika G. Gonzalez-Reyes, MD	San Antonio	AI	5th	Bexar	A
Donald J. Gordon, MD, PhD	Helotes	EM	5th	Bexar	D, Ex
Anupama Gotimukula, MD	San Antonio	AN	5th	Bexar	D, D-IMGS
Jonathan P. Grady, MD	Lake Jackson	OPH	8th	Brazoria	D
Michael S. Graves, MD	Austin	D	7th	Travis	SSD
Robert Daniel Greenberg, MD	Temple	EM	12th	Bell	D
Gerald Greenfield Jr., MD, PA	San Antonio	ORS	5th	Bexar	D
T. David Greer, MD	Henrietta	FM	13th	Wichita	D
Jedidiah James Grisel, MD	Wichita Falls	OTO	13th	Wichita	A, Ex
Albert T. Gros, MD	Buda	MDM	7th	Travis	D
Gary E. Gross, MD	Tyler	ON	11th	Smith	SSD
Robert D. Gross, MD	Dallas	PO	14th	Dallas	D
Angela M. Guerra, MD	Houston	FM	9th	Harris	A
Juan M. Guerrero, MD	Austin	PD	7th	Travis	D
Robert Tau Gunby Jr., MD	Dallas	OBG	14th	Dallas	Ex, P
James S. Guo, MD	Houston	AN	9th	Harris	D, Ex
Roy J. Guse, MD	Lufkin	ORS	10th	Angelina	D

Name	City	Specialty	District	County Medical Society	Codes
Leslie M. Haber, MD	Houston	PTH	9th	Harris	D
Steven E. Haber, MD	Houston	PUD	9th	Harris	D
Alison J. Haddock, MD	Houston	EM	9th	Harris	D, D-YPS
Lesca C. Hadley, MD	Cleburne	FPG	12th	Johnson	SSD
Trevor D. Hadley	Houston		9th	Harris	D-MSS
Stephen Haff	Dallas		14th	Dallas	D-MSS
Robert Ware Haley, MD	Dallas	IM	14th	Dallas	D
Christopher Shane Hall, MD	McKinney	FM	14th	Collin-Fannin	A
Harry Eugene Hall, MD	Lubbock	ORS	3rd	Lubbock	VC
Gregory A. Hamon, MD	San Antonio	GS	5th	Bexar	D
Ori Z. Hampel, MD	Pasadena	U	9th	Harris	D
Tom B. Hancher, MD	Columbus	IM	8th	Colorado-Fayette	P
Shannon Hancher-Hodges, MD	Bellaire	AN	9th	Harris	D
Gilberto A. Handal, MD	El Paso	ID	1st	El Paso	D, Ex
Madeline W. Harford, MD	Dallas	P	14th	Dallas	D
R. Andrew Harper III, MD	Houston	P	9th	Harris	D
Lindsey D. Harris, MD	Houston	OPH	9th	Harris	D
Vivian R. Hase, MD	Lubbock	FM	3rd	Lubbock	A-RFS
Arafat A. Hashwani, MD	Sugar Land	N	9th	Harris	A
Katharina Hathaway, MD	Austin	FM	7th	Travis	D
Gabrielle E. Hatton, MD	Houston	GS	9th	Harris	A
Eric J. Haufrect, MD	Houston	OBG	9th	Harris	A
Harris M. Hauser, MD	Bellaire	N	9th	Harris	D
Allan Louis Haynes Jr., MD	Lubbock	U	3rd	Lubbock	A
Steven Ray Hays, MD	Dallas	NEP	14th	Dallas	Ex, SSA
Ralph F. Heaven Jr., MD	Abilene	ON	13th	Big Country	D
Sarah Lynn Helfand, MD	Dallas	PD	14th	Dallas	D
Hattie E. Henderson, MD, CMD	Houston	FPG	9th	Harris	D
David Norman Henkes, MD	San Antonio	PTH	5th	Bexar	Ex
Justin Paul Hensley, MD	Corpus Christi	EM	6th	Nueces	A
Kim E. Higgins, DO	Fort Worth	FPG	13th	Tarrant	A
John W. Hinchey, MD	San Antonio	ORS	5th	Bexar	D
William Woolford Hinchey, MD	San Antonio	PTH	5th	Bexar	P
David Anthony Hnatow, MD	San Antonio	EM	5th	Bexar	D
Amy F. Ho, MD	Dallas	EM	14th	Dallas	D, SSA
Jessie W. Ho	Plano		14th	Dallas	Ex
Matthew D. Hoggatt, MD	Webster	U	9th	Harris	D
John Robert Holcomb, MD	San Antonio	PUD	5th	Bexar	D
Nicky R. Holdeman, MD	Houston	OPH	9th	Harris	A
Pamela D. Holder, MD	Horseshoe Bay	PTH	9th	Harris	D
Bradford W. Holland, MD	Waco	OTO	12th	McLennan	D, Ex, SSA
Charles Hollingsworth II, MD	Texarkana	PS	15th	Bowie	D
Grace L. Honles, MD	Austin	FM	7th	Travis	A
David R. Hoyer Jr., MD	Houston	EM	9th	Harris	A
Allen D. Hu	Houston		9th	Harris	A-MSS
Mei Melvin Hu, MD	Frisco	PMM	14th	Collin-Fannin	A
David Sheng Huang, MD	Wichita Falls	ORS	13th	Wichita	A
Hal Davis Huffman, MD	Graham	FM	13th	Young	A
Ann C. Hughes Bass, MD	Littlefield	FM	3rd	Lubbock	A
Felix Hull, MD	Austin	OBG	7th	Travis	D

Name	City	Specialty	District	County Medical Society	Codes
James Loyd Humphreys, MD	Helotes	PTH	5th	Bexar	D, Ex
Jerry Dean Hunsaker, MD	Corpus Christi	OPH	6th	Nueces	D
Eugene Pitts Hunt III, MD	Dallas	OBG	14th	Dallas	D
Cheryl Lynn Hurd, MD	Fort Worth	P	13th	Tarrant	D
James William Huston, MD	Midland	IM	2nd	Midland	D, VC
Ifeyinwa C. Ifeanyi-Pillette, MD	Houston	AN	9th	Harris	A
Kam Woon Ip, MD	Stephenville	FM	12th	Erath-Somervell-Comanche	D
Terah C. Isaacson, MD	Houston	CRS	9th	Harris	D
Sameer Islam, MD	Lubbock	IM	3rd	Lubbock	A
Shah Faizul Islam, MD	Corpus Christi	NEP	6th	Nueces	A
Robert E. Jackson, MD, MACP	Houston	IM	9th	Harris	Ex
Leah Hanselka Jacobson, MD	San Antonio	PD	5th	Bexar	D
Kambiz Jahadi, MD	Round Rock	CRS	7th	Williamson	D
Nishant B. Jalandhara, MD	Fort Worth	IM	13th	Tarrant	A
NoraJanjan, MD, MPSA, MBA	Navasota	RO	9th	Harris	D
Gina Mapes Jetter, MD	Tyler	N	11th	Smith	D
Laura P. Jimenez-Quintero, MD	The Woodlands	PTH	9th	Harris	A
Richard H. Johnigan, MD	Webster	OTO	9th	Harris	D
Bryan G. Johnson, MD	Frisco	IM	14th	Collin-Fannin	D, Ex
Gregory Johnson, MD, SFHM	Houston	HOS	8th	Brazoria	Ex
Luckett Johnson, MD	Houston	FM	9th	Harris	D
Richard B. Johnson, MD, PA	Kerrville	IM	5th	Kerr-Bandera	D
Zachary S. Jones, MD	Frisco	AN	14th	Dallas	A
Felicia L. Jordan, MD	Richmond	IM	9th	Harris	D
Anand Joshi, MD	Austin	PME	7th	Travis	A
Collin M. Juergens, MD	Temple	US	12th	Bell	D-RFS
Cynthia Ann Jumper, MD, MPH	Lubbock	IM	3rd	Lubbock	A, Ex
Hima Bindu Jyothi, MD	Plainview	PD	3rd	Hale-Floyd-Briscoe	A
Woody V. Kageler, MD	Fort Worth	PUD	13th	Tarrant	D
Jeffrey B. Kahn, MD	Austin	OTO	7th	Travis	D, SSD
Binal S. Kancherla, MD	Sugar Land	PDP	9th	Harris	A
Wendy Bay Kang, MD, JD	San Antonio	AN	5th	Bexar	D
Seth David Kaplan, MD	Frisco	PD	14th	Dallas	D
Shaheen Karim, MD	Corpus Christi	OPH	6th	Nueces	A
Ahmed O. Kaseb, MD	Pearland	ON	9th	Harris	A
Fareha Abid Kazi, MD	McKinney	NEP	14th	Collin-Fannin	A
Margaret Ann Kelley, MD	San Antonio	OBG	5th	Bexar	D
Alexander B. Kenton, MD	San Antonio	NPM	5th	Bexar	D
Yvonne Kew, MD, PhD	Houston	N	9th	Harris	D
Faraz A. Khan, MD	Houston	DR	9th	Harris	D
Rainer Anil Khetan, MD	Dallas	IM	14th	Dallas	D
Roger Sunil Khetan, MD	Dallas	IM	14th	Dallas	D
Michael Kim, MD	San Antonio	AN	5th	Bexar	A
Thomas J. Kim, MD, MPH	Austin	P	7th	Travis	D, Ex
Thomas Duke Kimbrough, MD	Galveston	GS	8th	Galveston	D
Austin Irvin King, MD	Abilene	OTO	13th	Big Country	P
Karl W. King, MD	Cypress	RO	9th	Harris	D
Travis G. King, MD	Plainview	FM	3rd	Hale-Floyd-Briscoe	A
Louis John Kirk III, MD	Longview	OBG	15th	Gregg-Upshur	Ex
Art L. Klawitter, MD	Needville	FM	8th	Fort Bend	D, EMER

Name	City	Specialty	District	County Medical Society	Codes
Kevin Wayne Klein, MD	Dallas	AN	14th	Dallas	D
Heidi C. Knowles, MD	Forney	EM	11th	Anderson-Leon	SSD
Alan David Koenigsberg, MD	Plano	P	14th	Collin-Fannin	A
Christine E. Koerner, MD	Houston	PD	9th	Harris	D
Gurneet Singh Kohli, MD	Austin	IM	7th	Travis	A
Megan K. Kressin, MD	Austin	PTH	7th	Travis	A
Russell W. H. Kridel, MD	Houston	FPS	9th	Harris	A
Vijay Kumar Krishnan, MD	Beaumont	AN	10th	Jefferson	D
Kyle Gregory Krohn, MD	Lufkin	IM	10th	Angelina	Ex
Gregory M. Kronberg, MD	Austin	AN	7th	Travis	D
Gus W. Krucke, MD	Houston	CCM	9th	Harris	A
Mark J. Kubala, MD	Beaumont	NS	10th	Jefferson	P
Craig Allen Kuhns, MD	Austin	OSS	7th	Travis	A
Pruthali Kulkarni	Fort Worth		13th	Tarrant	A-MSS
Kaparaboyna A. Kumar, MD	San Antonio	FM	5th	Bexar	D, VC
Paraag Kumar, MD	Austin	UCM	7th	Travis	A-YPS
Pradeep Kumar, MD	Austin	GE	7th	Travis	D, SSD
Prashant Kumar, MD	Lufkin	IM	10th	Angelina	A
Sushmitha Kurapati, MD	Austin	AN	7th	Travis	A
David L. Lakey, MD	Austin	MPD	7th	Travis	Ex
David Trueson Lam, MD	San Antonio	NPM	5th	Bexar	D
David T.H. Lam	Arlington		13th	Tarrant	D-MSS
Thomas J. Lambert Jr., MD	Tyler	D	11th	Smith	A
Amanda K. LaViolette, MD	Austin	IM	7th	Travis	A, SSD
Yolanda R. Lawson, MD	Dallas	OBG	14th	Dallas	D
Benjamin C. Lee, MD	Dallas	PD	14th	Dallas	Ex
Chevy Chu Lee, MD	McAllen	OPH	6th	Hidalgo-Starr	A
Ana L. Leech, MD	Houston	FM	9th	Harris	A
Daniel J. Leeman, MD	Austin	OTO	7th	Travis	D
Shaun D. Lehmann, MD	The Woodlands	PM	9th	Montgomery	SSA
Keith A. Lepak, MD	Little Elm	EM	14th	Denton	A
Roxann Alexis Lerma	El Paso		1st	El Paso	A-MSS
C. Turner Lewis III, MD	Dallas	PD	14th	Dallas	D
William Cannon Lewis, MD	San Antonio	CRS	5th	Bexar	A
Andrew Li-Yung Hing, MD	Katy	FM	9th	Harris	A
Warren E. Lichliter, MD	Dallas	CRS	14th	Dallas	D
Arthur Lim, MD	Missouri City	EM	9th	Harris	D
Dan L. Locker, MD	Brownwood	GS	4th	Central Texas	Ex
Asa C. Lockhart, MD, MBA	Tyler	AN	11th	Smith	Ex
Nathan P. Long, MD	Dallas	IM	14th	Dallas	D
Annalisa Lopez	Edinburg		6th	Hidalgo-Starr	A-MSS
Leonel Lopez, MD	San Antonio	FM	5th	Bexar	A
Anna M. Lozano, MD	Austin	GYN	7th	Travis	A
Matthew David Lynx, MD	Cedar Park	P	7th	Williamson	D
Jonathan E. MacClements, MD	Austin	FM	7th	Travis	A
Felicity L. Mack, MD	Buffalo	FM	9th	Harris	D
Marcella A. Madera, MD	Austin	NS	7th	Travis	A
Shane M. Magee, MD	Houston	IM	9th	Harris	A
Harris Majeed	Plano		14th	Dallas	A-MSS
Yasmin S. Maldonado, MD	Brownsville	IM	6th	Cameron-Willacy	D

Name	City	Specialty	District	County Medical Society	Codes
C. Bruce Malone III, MD	Austin	ORS	7th	Travis	P
Suzanne M. Manzi, MD	Houston	PMP	9th	Harris	A
Anna L. C. Mapp, MD	Houston	OPH	9th	Harris	A
Javier D. Margo Jr., MD	Rio Grande City	FM	6th	Hidalgo-Starr	D
Ferenc Markos, MD	The Woodlands	OBG	9th	Montgomery	D
R. Larry Marshall, MD	Fort Worth	RHU	13th	Tarrant	D
Azalia Veronica Martinez, MD	El Paso	FM	1st	El Paso	A
Juan Diego Martinez, MD	Shavano Park	IM	5th	Bexar	D
Luis H. Martinez, MD	Fort Worth	IM	13th	Tarrant	A
Milagros A. Martinez, MD	San Antonio	NEP	5th	Bexar	A
Joseph T. Martins, MD	Tyler	HO	11th	Smith	A
George Sealy Massingill, MD	Fort Worth	OBG	13th	Tarrant	D
Aurelio Matamoros Jr., MD	Houston	R	9th	Harris	D
Samuel E. Mathis, MD	Galveston	FM	8th	Galveston	A-RFS
Kenneth L. Mattox, MD	Houston	TS	9th	Harris	Ex
Paul Martin Mauk, MD	Houston	GE	9th	Harris	D
David C. May, MD	Lewisville	CD	14th	Denton	SSA
Patti Nelson May, MD	Lubbock	FM	3rd	Lubbock	A
Richard W. McCallum, MD	El Paso	GE	1st	El Paso	D
Danny Ken McCoy, MD	Corsicana	D	14th	Dallas	D
William M. McCrady, MD	Tyler	FM	11th	Smith	A
William T. McCunniff, MD	Woodway	FM	12th	McLennan	D
Scott Randall McDearmont, MD	Sulphur Springs	GS	14th	Hopkins-Franklin	A
Clint W. McHenry, DO	Woodway	FM	12th	McLennan	A
John Duncan McKeever, MD	Corpus Christi	ORS	6th	Nueces	D
Kevin Hood McKinney, MD	Galveston	END	8th	Galveston	Ex
Ronnie A. McMurry, MD	Jasper	FM	10th	Jasper-Newton	D
Ankur D. Mehta, DO	Houston	PM	9th	Harris	A
Jaideep H. Mehta, MD	Houston	AN	9th	Harris	D
Sejal S. Mehta, MD	Allen	P	14th	Collin-Fannin	A
John A. Menchaca, MD	San Antonio	PD	5th	Bexar	D
Isabel C. Menendez, MD	Portland	R	6th	San Patricio-Aransas-Refugio	D, Ex
Diana Mercado-Marmarosh, MD	Houston	FM	8th	Victoria-Goliad-Jackson	A
David Wayne Mercier, MD	Dallas	AN	14th	Dallas	D
Darlene Metter, MD, FACR	San Antonio	DR	5th	Bexar	D
Evan C. Meyer, MD	Wichita Falls	EM	13th	Wichita	A
James P. Michaels, MD	Tyler	PM	11th	Smith	D
David Scott Miller, MD	Dallas	GO	14th	Dallas	D
Hillary Miller, MD	Austin	FM	7th	Travis	D
Hector Miranda-Grajales, MD	Austin	PM	7th	Travis	A
Ambir R. Mirza, MD	Lubbock	IM	3rd	Lubbock	A
Sandeep G. Mistry, MD	Round Rock	U	7th	Travis	SSD
Li-Yu H. Mitchell, MD	Tyler	FM	11th	Smith	D
Angela N. Moemeka, MD	Coppell	PD	14th	Dallas	D
Jennifer Chibogu Molokwu, MD	El Paso	FM	1st	El Paso	D
Kimberly E. Monday, MD	Pearland	N	9th	Harris	D
Jacob J. Moore, MD	Corpus Christi	OPH	6th	Nueces	D
Benjamin R. Morrissey, MD	Dallas	EM	14th	Dallas	D
Robert B. Morrow, MD, MBA	Sugar Land	FM	9th	Harris	D

Name	City	Specialty	District	County Medical Society	Codes
Jesse Moss Jr., MD	Live Oak	OTO	5th	Bexar	D
Clifford K. Moy, MD	Frisco	P	14th	Dallas	D, EMER
Raafia B. Muhammad, MD	Cypress	PHP	7th	Travis	A-IMGS
Erika Maria Sehne Munch, MD	San Antonio	REN	5th	Bexar	A
Bonnie Muncy, MD	Andrews	FM	2nd	Andrews	D
Murtaza Mussaji, DO	Houston	IM	9th	Harris	A
Lubna Naeem, MD	San Antonio	IM	5th	Bexar	D
Jayaram B. Naidu, MD	Odessa	IM	2nd	Ector	A
Monisha Narayanan	Lubbock		3rd	Lubbock	A
Santhosshi Narayanan, MD	Houston	IM	9th	Harris	A
John Joseph Nava, MD	San Antonio	FM	5th	Bexar	D
Celia B. Neavel, MD	Austin	FM	7th	Travis	D
Vincent G. Nelson, MD	Houston	AN	9th	Harris	A
Sergiy Nesterenko, MD	Lubbock	OSS	3rd	Lubbock	A
Lonzetta L. Newman, MD	Houston	IM	9th	Harris	D
Mark L. Nichols, MD	Houston	OTO	9th	Harris	D
David Christian Nickeson, MD	Seabrook	PUD	8th	Galveston	VC
Rupesh Nigam, MD	Pearland	IM	9th	Harris	A
Richard L. Noel, MD	Houston	P	9th	Harris	D, SSD
Stacy L. Norrell, MD	Houston	AN	9th	Harris	D
Daniel A. Nwachokor, MD	Sugar Land	FM	9th	Harris	D-RFS
William Ellis O'Mara Jr., MD	Beaumont	OTO	10th	Jefferson	D
Kehinde O. Ogunmakin, MD	Katy	D	9th	Harris	A
Patrick O. Ojeaga	McAllen		6th	Hidalgo-Starr	D-MSS
Thomas J. Oliverson, MD	Cypress	AN	9th	Harris	A
Stacy E. Ong, MD	Round Rock	U	7th	Travis	SSA
Charles O. Onyeama, MD	Trophy Club	PD	14th	Denton	D
Kalarickal J. Oommen, MD	Lubbock	N	3rd	Lubbock	D
Carla F. Ortique, MD	Houston	OBG	9th	Harris	D
Rachel M. Osborn, MD	Flower Mound	OBG	14th	Denton	A
Debra M. Osterman, MD	Cypress	P	9th	Harris	D
George A. Osuchukwu, MD	Victoria	NEP	8th	Victoria-Goliad-Jackson	D
Graves T. Owen, MD	Round Rock	APM	7th	Travis	A
Michelle C.M. Owens, DO	Austin	FM	7th	Travis	A
Dennis Samuel Pacl, MD	Manor	PLM	7th	Travis	A
Udaya Bhaskar Padakandla, MD	Carrollton	AN	14th	Denton	D
David Mario Palafox, MD	El Paso	FM	1st	El Paso	D
Bruce Lee Palmer, MD	Wichita Falls	CD	13th	Wichita	D
Robert W. Palmer, Sr., MD	Marshall	PTH	15th	Harrison	A
Karl G. Pankratz, MD	Lubbock	ORS	3rd	Lubbock	D
Thornwell Hay Parker III, MD	Dallas	PS	14th	Dallas	SSA
Thomas J. Parr, MD	Sugar Land	OSM	9th	Harris	A
Perry Glenn Pate, MD	Irving	ID	14th	Dallas	A
Nimesh H. Patel, MD	Dallas	NS	14th	Dallas	SSD
Vatsal B. Patel, MD	San Antonio	RO	5th	Bexar	A
Madhavi Patnana, MD	Houston	DR	9th	Harris	A
Bradford S. Patt, MD	Houston	OTO	9th	Harris	D
Debra A. Patt, MD	Austin	ON	7th	Travis	Ex, SSA
Eddie L. Patton Jr., MD	Houston	N	9th	Harris	D
Lee Ann Pearse, MD	Dallas	PDC	14th	Dallas	Ex

Name	City	Specialty	District	County Medical Society	Codes
Daniel B. Pearson III, MD	Dallas	P	14th	Dallas	D
Mario Pena Jr., MD	Lubbock	FM	3rd	Lubbock	A
Juan Rodrigo Perez, MD	El Paso	FM	1st	El Paso	D
Charles M. Perricone, MD	Henderson	FM	11th	Rusk	Ex
Steven M. Petak, MD	Houston	END	9th	Harris	VC
Mary Dahlen Peterson, MD	Corpus Christi	AN	6th	Nueces	D
Gregory J. Phillips, MD	Fort Worth	IM	13th	Tarrant	D
Stuart C. Pickell, MD, FACP	Fort Worth	MPD	13th	Tarrant	D
Jack W. Pierce, MD	Austin	OPH	7th	Travis	D, SSD
Jurswin Coffy Pieternelle, MD	Beaumont	OBG	10th	Jefferson	A
Susan M. Pike, MD	Georgetown	PS	7th	Williamson	A, SSD, VC
David M. Pinkstaff, MD	Waco	U	12th	McLennan	A
Jeffery Matthew Pinnow, MD	Odessa	EM	2nd	Ector	D
Evan G. Pivalizza, MD	Houston	AN	9th	Harris	D, SSD
John Edward Pliska, MD	Temple	PDC	12th	Bell	D
Clausyl Plummer, MD	San Antonio	PM	5th	Bexar	A
Anne M. Ponce De Leon, MD	Sugar Land	FM	9th	Harris	D
Tucker D. Pope	Austin		7th	Travis	D-MSS
Cindy Renea Porter, MD	Texarkana	PD	15th	Bowie	VC
Edward J. Prejean III, MD	Irving	AN	14th	Dallas	D
Autumn L. Pruette, MD	Houston	PD	9th	Harris	A
Pervaiz Rahman, MD	Dallas	GE	14th	Dallas	D
Ben G. Raimer, MD	Galveston	PD	8th	Galveston	SSA
A. Melinda Rainey, MD	Austin	PO	7th	Travis	A
Bindu Raju, MD	Harker Heights	IM	12th	Bell	D
Rajam S. Ramamurthy, MD	San Antonio	PD	5th	Bexar	D
Steven David Ramos, MD	San Antonio	IM	5th	Bexar	A
Mark B. Randolph, MD	San Marcos	FM	7th	Tri-County	D
Ann E. Ranelle, DO	Fort Worth	OPH	13th	Tarrant	D
Fara Ranjbaran, MD	Austin	IM	7th	Travis	A
U. Prabhakar Rao, MD	Odessa	GE	2nd	Ector	D
Vivek U. Rao, MD	Odessa	AI	2nd	Ector	Ex
Adam V. Ratner, MD	San Antonio	R	5th	Bexar	D
Fernando F. Raudales, MD	El Paso	NEP	1st	El Paso	A
Don Robert Read, MD	Dallas	CRS	14th	Dallas	Ex, P
Larry E. Reaves, MD	Fort Worth	PS	13th	Tarrant	Ex
Elizabeth M. Rebello, MD	Houston	AN	9th	Harris	D
Sherine E Boyd Reno, MD	Dallas	PM	14th	Collin-Fannin	D
Edward R. Rensimer, MD	Houston	ID	9th	Harris	D
Roberto Mauro Rey, MD	Raymondville	PD	6th	Cameron-Willacy	D
Jeffrey S. Richards, MD	League City	AN	8th	Galveston	D
H. Miller Richert, MD	Abilene	OPH	13th	Big Country	D
Neal J. Richmond, MD	Fort Worth	EM	13th	Tarrant	A
Jane Catherine Rider, MD	San Angelo	PD	4th	Concho Valley	D, VC
Humberto J. Rivas, MD	Gonzales	PD	5th	Gonzales	D
Wagdy S. Rizk, MD	Beaumont	OAR	10th	Jefferson	A
Carlos Rizo-Patron, MD	Lubbock	ICE	3rd	Lubbock	Ex
James T. Roberts	North Richland Hills		8th	Galveston	A-MSS
Eldon Stevens Robinson, MD	Lubbock	FM	3rd	Lubbock	D

Name	City	Specialty	District	County Medical Society	Codes
Noel Keith Robinson Jr., MD	Abilene	IM	13th	Big Country	A
Regina E. Rodman, MD	Houston	FPS	9th	Harris	A
Robert J. Rogers, MD	Fort Worth	AI	13th	Tarrant	A
J. James Rohack, MD	Galveston	CD	8th	Galveston	P
Carlos E. Romero, MD	Houston	AN	9th	Harris	D
Harris S. Rose, MD	Austin	ORS	7th	Travis	D
Susan N. Rossmann, MD	Houston	PTH	9th	Harris	D
Ritchie Rosso Jr., MD	Odessa	D	2nd	Ector	A
Stephanie D. Roth, MD	Round Rock	FM	7th	Travis	D
Malcolm J. Rude, MD	College Station	PS	12th	Brazos-Robertson	D
Manish Rungta, MD	Webster	GE	9th	Harris	D
Jennifer R. Rushton, MD	Austin	PTH	5th	Bexar	A-YPS, D, Ex, SSA
Ronald M. Rust, MD	Bryan	DR	12th	Brazos-Robertson	D
Assad Joe Saad, MD	Dallas	PTH	14th	Dallas	D
Habeeb Munir Salameh, MD	Galveston	IM	8th	Galveston	Ex
Dora L. Salazar, MD	Austin	FM	7th	Travis	D
Ghassan Salman, MD, MBA	Austin	IM	7th	Travis	D, Ex
Mammen A. Sam, MD	Pearland	HOS	8th	Brazoria	D
Roberto San Martin, MD	San Antonio	OPH	5th	Bexar	D
Alberto Santos, DO	San Marcos	FM	7th	Tri-County	D
George D. Santos, MD	Houston	P	9th	Harris	D
Arindam Sarkar, MD	Houston	FM	9th	Harris	A, A-RFS
J. Clay Sawyer, MD	Waco	P	12th	McLennan	SSA
C. M. Schade, MD, PhD	Mesquite	PMM	14th	Dallas	SSD
Kurt A. Schoppe, MD	Grapevine	DR	13th	Tarrant	D
Dean Allen Schultz, MD	Abilene	FM	13th	Big Country	Ex
John Stuart Scott, DO	Dallas	AN	14th	Dallas	D
Leslie Harold Secrest, MD	Dallas	P	14th	Dallas	Ex
Angela D. Self, MD	Grapevine	IM	13th	Tarrant	D
Pollachi Selvakumarraj, MD, PA	Navasota	IM	9th	Austin-Grimes-Waller	D
Halsey M. Settle III, MD	Austin	OPH	7th	Travis	A
Elizabeth Ruth Seymour, MD	Denton	FM	14th	Denton	D
Arathi A. Shah, MD	Arlington	PD	14th	Dallas	D
Jayesh B. Shah, MD	San Antonio	UM	5th	Bexar	D, Ex
Koonj A. Shah, MD	Austin	PCC	7th	Travis	A
Rahul Shah	Galveston		8th	Galveston	D-MSS
Shalin Shah	College Station		12th	Brazos-Robertson	A-MSS
Umair A. Shah, MD	Houston	IM	9th	Harris	D
Umang Hasmukhlal Shah, MD	San Antonio	IC	5th	Bexar	A
Amber D. Shamburger, MD	Friendswood	OBG	9th	Harris	D
Mark M. Shelton, MD	Fort Worth	PDI	13th	Tarrant	D
John Milton Shepherd, MD	San Antonio	AN	5th	Bexar	A
Todd R. Shepler, MD	Cedar Park	OPR	7th	Travis	D
Gary J. Sheppard, MD	Houston	IM	9th	Harris	D
Shaina M. Sheppard, MD	Houston	ACA	9th	Harris	A
Akaanksh Shetty	Houston		1st	El Paso	D-MSS
David G. Shulman, MD, PA	San Antonio	OPH	5th	Bexar	D
Angela Siler-Fisher, MD	Houston	EM	9th	Harris	D
Victor A. Simms, MD	Pearland	IM	9th	Harris	Ex
Mina K. Sinacori, MD	Houston	OBG	9th	Harris	D

Name	City	Specialty	District	County Medical Society	Codes
Sapna Singh, MD	Sugar Land	PD	8th	Fort Bend	D
Linda M. Siy, MD	Fort Worth	FM	13th	Tarrant	D
Alan W. Skolnick, MD	Sugar Land	U	9th	Harris	D
Sarah I. Smiley, DO	Austin	HOS	7th	Travis	D
Evans S. Smith, MD	Tyler	EM	11th	Smith	A
Gretta Smith	Temple		12th	Brazos-Robertson	D-MSS
J. Marvin Smith III, MD	San Antonio	TS	5th	Bexar	D
J. Brannan Smoot, MD	Austin	ORS	7th	Travis	SSA
Michael J. Snyder, MD	Houston	CRS	9th	Harris	A
Richard Wesley Snyder II, MD	Dallas	CD	14th	Dallas	Ex
Charles E. Soderstrom, MD	Houston	DR	9th	Harris	D
Iveth Soza, DO	San Antonio	FM	5th	Bexar	A
Michael E. Speer, MD	Houston	NPM	9th	Harris	P
V. O. Speights Jr., DO	Temple	PTH	12th	Bell	SSD
Susanna C. Spence, MD	Missouri City	R	9th	Harris	A
Brent A. Spencer, MD	Frisco	D	14th	Collin-Fannin	A
Adam L. Spengler, MD	Corpus Christi	OPH	6th	Nueces	A
Theodore J. Spinks, MD	Georgetown	NS	7th	Williamson	D
Pranavi V. Sreeramoju, MD	Dallas	ID	14th	Dallas	D
Janice Ann Stachowiak, MD	Lubbock	IM	3rd	Lubbock	D
Horis Tilton Stedman, MD	Marble Falls	GP	7th	Burnet-Lampasas	A
Marian D. Steininger, MD	Allen	OBG	14th	Collin-Fannin	D
Nicholas P. Steinour, MD	Austin	EM	12th	McLennan	D-YPS
Charlotte M. Stelly-Seitz, MD	Houston	PM	9th	Harris	D
Charles Herbert Stern, MD	Waco	FM	12th	McLennan	A
Lynn N. Stewart, MD	Austin	FM	7th	Travis	A
Matthew Emanuel Stotz, MD	Fredericksburg	N	5th	Hill Country	D
Susan M. Strate, MD	Wichita Falls	PTH	13th	Wichita	A, Ex
Richard Strax, MD	Houston	VIR	9th	Harris	D
William Dean Strinden, MD	Lufkin	PS	10th	Angelina	D
Angela K. Sturm, MD	Houston	FPS	9th	Harris	D
Spencer H. Su, MD	Sugar Land	NEP	9th	Harris	D
Alexander P. Sudarshan, MD	Brownsville	OPH	6th	Cameron-Willacy	D
Irvin Sulapas, MD	Houston	FM	9th	Harris	D
Rajeev Suri, MD	San Antonio	R	5th	Bexar	D
Robert Eduard Suter, DO	Dallas	EM	14th	Dallas	D
Laurie Jayne Sutor, MD	Bedford	PTH	14th	Dallas	D
Sarah L. Svoboda, MD	Houston	EM	9th	Harris	D
Lisa Louise Swanson, MD	Dallas	PD	14th	Dallas	D
Bernard T. Swift Jr., DO, MPH	San Antonio	OM	5th	Bexar	D
Arthur L. Taitel, MD	Houston	GP	9th	Harris	D
Rosa A. Tang, MD	Houston	OPH	9th	Harris	D
James A. Tarbox, MD	Lubbock	AI	3rd	Lubbock	A
Marc T. Taylor, MD	San Antonio	PS	5th	Bexar	D
Lisa C. Taylor-Kennedy, MD	Dallas	AN	14th	Dallas	D
Brian W. Temple, MD	Austin	PD	7th	Travis	A, A-YPS
Robert Mayo Tenery Jr., MD	Dallas	OPH	14th	Dallas	P
Jason V. Terk, MD	Keller	PD	13th	Tarrant	Ex
Frank Vance Terrell, MD	Stephenville	OPH	12th	Erath-Somervell-Comanche	A
Jenny Thomas Jacob, MD	Killeen	IM	12th	Bell	D

Name	City	Specialty	District	County Medical Society	Codes
John J. Thoppil, MD	Austin	OBG	7th	Travis	SSD
Lyle Sheldon Thorstenson, MD	Dallas	OPH	14th	Dallas	Ex
Andrew B. Thyen, MD	Tyler	FM	11th	Smith	D
Bao N. To, MD	Houston	R	9th	Harris	A
David N. Tobey Jr., MD	Austin	OTO	7th	Travis	A
Joe M. Todd, MD	Fort Worth	ORS	13th	Tarrant	D
Elizabeth Torres, MD	Sugar Land	IM	9th	Harris	Ex
Emilio M. Torres, MD	Austin	OBG	7th	Travis	D
Theresa Q. Tran, MD	Houston	EM	9th	Harris	A
Xuan Kim Tran, MD	Austin	FM	7th	Travis	D
Roberto Trevino Jr., MD	San Antonio	IM	5th	Bexar	A
Zoltan Trizna, MD, PhD	Austin	D	7th	Travis	D
John Morrow Truelson, MD	Dallas	OTO	14th	Dallas	D
Elizabeth Truong, MD	Austin	P	7th	Travis	A
January Y. Tsai, MD	Houston	ACA	9th	Harris	A
David F. Turbeville, MD	Fort Worth	NPM	13th	Tarrant	A
Dexter G. Turnquest, MD	Houston	GS	9th	Harris	D
Edward Wilmar Tuthill, MD	Dallas	P	14th	Dallas	Ex
Roxanne Marie Tyroch, MD	El Paso	IM	1st	El Paso	D, Ex
Luis Hernando Urrea II, MD	El Paso	OSM	1st	El Paso	D
Stephen J. Utts, MD	Austin	GE	7th	Travis	SSA
Caroline Leilani Valdes, MD	Victoria	PTH	8th	Victoria-Goliad-Jackson	D
Joseph S. Valenti, MD	Denton	OBG	14th	Denton	D
Vani S. Vallabhaneni, MD	Austin	SME	7th	Travis	A
Ryan Van Ramshorst, MD	San Antonio	PD	5th	Bexar	SSD
David Vanderpool, MD	Dallas	GS	14th	Dallas	P
John R. Vanderzyl, MD	Sugar Land	FM	9th	Harris	A
Robert C. Vanzant, MD	Houston	FM	9th	Harris	D
Daniel Wiley Varga, MD	Arlington	IM	14th	Dallas	D
Surendra K. Varma, MD	Lubbock	PDE	3rd	Lubbock	A
Heather H. Vasser, MD	Columbus	GS	8th	Colorado-Fayette	D
Maria C. Robles Velasco, MD	Victoria	IM	8th	Victoria-Goliad-Jackson	A
Michael Ian Vengrow, MD	Plano	N	14th	Dallas	D
Aruna Venkatesh, MD	San Antonio	END	5th	Bexar	A
Joe B. Ventimiglia, MD	Dallas	FM	14th	Dallas	D
Gerard Joseph Ventura, MD	Nacogdoches	ON	10th	Nacogdoches-San Augustine	D
Daniel Joseph Verret, MD	Plano	FPS	14th	Collin-Fannin	A
Stephanie M. Vertrees, MD	Round Rock	N	7th	Travis	D
Paul G. Vigo, MD	Austin	AI	7th	Travis	SSA
Christopher D. Vije, MD	Austin	PMM	7th	Travis	A
Daniel V. Vijjeswarapu, MD	Corpus Christi	PD	6th	Nueces	D
John F. Villacis, MD	Austin	AI	7th	Travis	D
E. Linda Villarreal, MD	Edinburg	IM	6th	Hidalgo-Starr	Ex
Victor Lee Vines, MD	Ponder	ADM	14th	Denton	D, VC
David D. Vineyard, MD	Nacogdoches	OBG	10th	Nacogdoches-San Augustine	VC
Carlos J. Vital, MD	Houston	AI	9th	Harris	D
Veer D. Vithalani, MD	Fort Worth	EM	13th	Tarrant	A
Robert Allen Vogel, MD	Midland	IM	2nd	Midland	D

Name	City	Specialty	District	County Medical Society	Codes
Davor Vugrin, MD	Lubbock	HO	3rd	Lubbock	D
Richard Lee Wallner, MD	Desoto	GYN	14th	Dallas	A
Ronald S. Walters, MD	Houston	ON	9th	Harris	D
Jim Walton, DO, MBA	Dallas	IM	14th	Dallas	D
Stanley Wang, MD, JD, MPH	Austin	CD	7th	Travis	D, SSD
Russell Scott Warren, MD	Waco	OMF	12th	McLennan	D
David Webster, MD, MBA	San Antonio	FM	5th	Bexar	D
Arlo F. Weltge, MD, MPH	Bellaire	EM	9th	Harris	Ex
Sara A. Westgate, MD, PhD	Austin	N	7th	Travis	SSD
Edward Wheeler, MD	Houston	PM	8th	Galveston	D
Chad White, MD	Hamlin	FM	13th	Big Country	VC
Stephen E. Whitney, MD	Houston	PD	9th	Harris	D
Andrew J. Widmer, MD	Temple	IM	12th	Bell	D, D-RFS
Thomas C. Wiener, MD	Houston	PS	9th	Harris	A
Alexis A. Wiesenthal, MD	San Antonio	IM	5th	Bexar	A
George W. Williams II, MD	Bellaire	AN	9th	Harris	D
Jonathan Wayne Williams, MD	Wichita Falls	FM	13th	Wichita	D
Wendell H. Williams III, MD	Houston	AN	9th	Harris	A
Dan A. Willis, MD	Fort Worth	OPH	13th	Tarrant	A
Barbara J. Wilson, MD	Houston	HS	9th	Harris	A
Michael E. Wimmer, MD	Fort Worth	PM	13th	Tarrant	A
Kevin Scott Winfield, MD, MBA	Houston	IM	9th	Harris	D
Robert E. Wolf, MD	Waco	OSM	12th	McLennan	D
Kristin A. Wong, MD	Austin	PM	7th	Travis	SSD
Sara S. W. Dyrstad, MD	Odessa	DR	2nd	Ector	A-YPS
Asha Wurdeman, DO	Sugar Land	PLM	8th	Fort Bend	A
Shiraz A. Yazdani, MD	Lubbock	AN	3rd	Lubbock	A
Crystal J. Yeo, MD	Houston	N	9th	Harris	A
Alisha Y. Young, MD	Houston	PCC	9th	Harris	A
David Lawrence Young, MD	Tyler	GS	11th	Smith	D
Sherif Z. Zaafran, MD	Houston	AN	9th	Harris	Ex
Belda Zamora, MD	Austin	FM	7th	Travis	D
Guadalupe Zamora, MD	Austin	FM	7th	Travis	D
Gabriela M. Zandomeni, MD	Rowlett	OBG	14th	Dallas	D-YPS
Jay R. Zdunek, DO	Austin	FM	7th	Travis	A
Yasser Fahmy Zeid, MD	Longview	OBG	15th	Gregg-Upshur	Ex
Thomas Michael Zellers, MD	Dallas	PDC	14th	Dallas	D
Mateo Ziu, MD	Austin	NS	7th	Travis	A

2018 Delegates and Alternates by County Medical Society*
As of 4/20/2018

Andrews CMS
- Delegate: Bonnie Muncy, MD

Angelina CMS
- Delegate: Roy J. Guse, MD
- Delegate: William Dean Strinden, MD
- Alternate: Prashant Kumar, MD

Austin-Grimes-Waller CMS
- Delegate: Pollachi Selvakumarraj, MD, PA

Bell CMS
- Delegate: Lisa Jennifer Go, MD
- Delegate: Robert Daniel Greenberg, MD
- Delegate: John Edward Pliska, MD
- Delegate: Bindu Raju, MD
- Delegate: Jenny Thomas Jacob, MD
- Delegate: Andrew J. Widmer, MD

Bexar CMS
- Delegate: Rajaram Bala, MD
- Delegate: Michael A. Battista, MD
- Delegate: Josie Ann Cigarroa, MD
- Delegate: Chelsea I. Clinton, MD
- Delegate: Suresh Venkayya Dutta, MD
- Delegate: John D. Edwards, MD
- Delegate: Harold V. Gaskill, MD
- Delegate: Stephen D. Gelfond, MD
- Delegate: Alice Kim Gong, MD
- Delegate: Donald Joseph Gordon, MD, PhD
- Delegate: Anupama Gotimukula, MD
- Delegate: Gerald Q. Greenfield Jr., MD, PA
- Delegate: Gregory A. Hamon, MD
- Delegate: John W. Hinchey, MD
- Delegate: David Anthony Hnatow, MD
- Delegate: John Robert Holcomb, MD
- Delegate: James Loyd Humphreys, MD
- Delegate: Leah Hanselka Jacobson, MD
- Delegate: Wendy Bay Kang, MD, JD
- Delegate: Margaret Ann Kelley, MD
- Delegate: Alexander B. Kenton, MD
- Delegate: Kaparaboyna Ashok Kumar, MD
- Delegate: David Trueson Lam, MD
- Delegate: Juan Diego Martinez, MD
- Delegate: John A. Menchaca, MD
- Delegate: Darlene Metter, MD, FACR
- Delegate: Jesse Moss Jr., MD
- Delegate: Lubna Naeem, MD
- Delegate: John Joseph Nava, MD
- Delegate: Rajam S. Ramamurthy, MD
- Delegate: Adam V. Ratner, MD
- Delegate: Jennifer R. Rushton, MD
- Delegate: Roberto San Martin, MD
- Delegate: Jayesh B. Shah, MD

Bexar CMS (continued)
- Delegate: David George Shulman, MD, PA
- Delegate: J. Marvin Smith III, MD
- Delegate: Rajeev Suri, MD
- Delegate: Bernard T. Swift Jr., DO, MPH
- Delegate: Marc T. Taylor, MD
- Delegate: David Webster, MD, MBA
- Alternate: Brittany Lynn Bickelhaupt, MD
- Alternate: Brian T. Boies, MD
- Alternate: Dianna Mosley Burns-Banks, MD
- Alternate: Erika G. Gonzalez-Reyes, MD
- Alternate: Donald Joseph Gordon, MD, PhD
- Alternate: Michael Kim, MD
- Alternate: David Trueson Lam, MD
- Alternate: William Cannon Lewis, MD
- Alternate: Leonel Lopez, MD
- Alternate: Milagros A. Martinez, MD
- Alternate: Erika Maria Sehne Munch, MD
- Alternate: Lubna Naeem, MD
- Alternate: Vatsal B. Patel, MD
- Alternate: Clausyl Plummer, MD
- Alternate: Steven David Ramos, MD
- Alternate: Adam V. Ratner, MD
- Alternate: Umang Hasmukhlal Shah, MD
- Alternate: John Milton Shepherd, MD
- Alternate: Iveth Soza, DO
- Alternate: Roberto Trevino Jr., MD
- Alternate: Aruna Venkatesh, MD
- Alternate: Alexis A. Wiesenthal, MD

Big Country CMS
- 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

Bowie CMS
- Delegate: Charles E. Hollingsworth II, MD

Brazoria CMS
- Delegate: Jonathan P. Grady, MD
- Delegate: Mammen A. Sam, MD

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

Brooks-Duval-Jim Wells CMS
- Delegate: Mauricio Bandeira-Teixeira, MD

Burnet-Lampasas CMS
- Delegate: Peter Davenport, MD
- Alternate: Horis Tilton Stedman, MD

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

Cameron-Willacy CMS
- Delegate: Yasmin Scarlett Maldonado, MD
- Delegate: Roberto Mauro Rey, MD
- Delegate: Alexander Pradip Sudarshan, MD

Collin-Fannin CMS
- Delegate: Brent B. Belvin, MD
- Delegate: Carrie E. De Moor, MD
- Delegate: Neha V. Dhudshia, MD
- Delegate: Marlene Diaz, MD
- Delegate: Aimee C. Garza, MD
- Delegate: Bryan G. Johnson, MD
- Delegate: Sherine E Boyd Reno, MD
- Delegate: Marian D. Steininger, MD
- Alternate: Tracey Ann Banks, MD
- Alternate: Robert W. Brobst Jr., MD
- Alternate: Peter Andrew Brokish, MD
- Alternate: Jason R. Fletcher, DO
- Alternate: Christopher Shane Hall, MD
- Alternate: Mei Melvin Hu, MD
- Alternate: Fareha Abid Kazi, MD
- Alternate: Alan David Koenigsberg, MD
- Alternate: Sejal S. Mehta, MD
- Alternate: Brent A. Spencer, MD
- Alternate: Daniel Joseph Verret, MD

Colorado Basin CMS
- Delegate: James Ray Burleson, MD

Colorado-Fayette CMS
- Delegate: Heather H. Vasser, MD

Concho Valley CMS
- Delegate: Bradly Bundrant, MD, MPH
- Delegate: Jane Catherine Rider, MD
- Alternate: Kathleen A. Cubine, DO

Dallas CMS
- Delegate: Drew Wilson Alexander, MD
- Delegate: Christine Ann Becker, MD
- Delegate: Justin M. Bishop, MD
- Delegate: Adam C. Carter, MD
- Delegate: William Hampton Caudill, MD
- Delegate: Vella Victoria Chancellor, MD
- Delegate: Samuel J. Chantilis, MD
- Delegate: Christopher Sung Jin Chun, MD
- Delegate: Wendy M. Chung, MD, MSPH
- Delegate: Shashi K. Dharma, MD
- Delegate: Walter Francis Evans II, MD
- Delegate: Lauren Cortell Fine, MD
- Delegate: Juliana M. Fort, MD
- Delegate: Raymond L. Fowler, MD
- Delegate: Deborah Anne Fuller, MD
- Delegate: Angela Fulgham Gardner, MD
- Delegate: John Russell Gilmore, MD
- Delegate: Victor Gonzalez, MD
- Delegate: Robert D. Gross, MD

Dallas CMS (continued)
- Delegate: Robert Ware Haley, MD
- Delegate: Madeline Weinstein Harford, MD
- Delegate: Sarah Lynn Helfand, MD
- Delegate: Amy F. Ho, MD
- Delegate: Eugene Pitts Hunt III, MD
- Delegate: Seth David Kaplan, MD
- Delegate: Rainer Anil Khetan, MD
- Delegate: Roger Sunil Khetan, MD
- Delegate: Kevin Wayne Klein, MD
- Delegate: Yolanda R. Lawson, MD
- Delegate: C. Turner Lewis III, MD
- Delegate: Warren E. Lichliter, MD
- Delegate: Nathan P. Long, MD
- Delegate: Danny Ken McCoy, MD
- Delegate: David Wayne Mercier, MD
- Delegate: David Scott Miller, MD
- Delegate: Angela N. Moemeka, MD
- Delegate: Benjamin R. Morrissey, MD
- Delegate: Clifford K. Moy, MD
- Delegate: Daniel B. Pearson III, MD
- Delegate: Edward Joseph Prejean III, MD
- Delegate: Pervaiz Rahman, MD
- Delegate: Assad Joe Saad, MD
- Delegate: John Stuart Scott, DO
- Delegate: Arathi A. Shah, MD
- Delegate: Pranavi V. Sreeramoju, MD
- Delegate: Robert Eduard Suter, DO
- Delegate: Laurie Jayne Sutor, MD
- Delegate: Lisa Louise Swanson, MD
- Delegate: Lisa Carole Taylor-Kennedy, MD
- Delegate: John Morrow Truelson, MD
- Delegate: Daniel Wiley Varga, MD
- Delegate: Michael Ian Vengrow, MD
- Delegate: Joe B. Ventimiglia, MD
- Delegate: Jim Walton, DO, MBA
- Delegate: Thomas Michael Zellers, MD
- Alternate: Gary Bloomgarden, MD
- Alternate: Zachary S. Jones, MD
- Alternate: Perry Glenn Pate, MD
- Alternate: Richard Lee Wallner, MD

Denton CMS
- Delegate: Charles O.u Onyeama, MD
- Delegate: Udaya Bhaskar Padakandla, MD
- Delegate: Elizabeth Ruth Seymour, MD
- Delegate: Joseph S. Valenti, MD
- Delegate: Victor Lee Vines, MD
- Alternate: Folahan Kolawole Ayoola, MD
- Alternate: Roshni Kandyil Foster, MD, PhD
- Alternate: Keith A. Lepak, MD
- Alternate: Rachel M. Osborn, MD

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

Ector CMS
Delegate: Louise N. De Boer, MD
Delegate: Jeffery Matthew Pinnow, MD
Delegate: U. Prabhakar Rao, MD
Alternate: Jayaram B. Naidu, MD
Alternate: Ritchie Rosso Jr., MD

El Paso CMS
Delegate: Manuel L. Acosta, MD
Delegate: Ogechika Karl Alozie, MD
Delegate: Elaine Mowinski Barron, MD
Delegate: Gilberto A. Handal, MD
Delegate: Richard W. McCallum, MD
Delegate: Jennifer Chibogu Molokwu, MD
Delegate: David Mario Palafox, MD
Delegate: Juan Rodrigo Perez, MD
Delegate: Roxanne Marie Tyroch, MD
Delegate: Luis Hernando Urrea II, MD
Alternate: James Byron Boone III, MD
Alternate: Alison L. Days, MD, MPH
Alternate: Andres S. Enriquez, MD
Alternate: Azalia Veronica Martinez, MD
Alternate: Fernando F. Raudales, MD

Erath-Somervell-Comanche CMS
Delegate: Kam Woon Ip, MD
Alternate: Frank Vance Terrell, MD

Fort Bend CMS
Delegate: Art L. Klawitter, MD
Delegate: Sapna Singh, MD
Alternate: Asha Wurdeman, DO

Galveston CMS
Delegate: Mary Josephine Godinich, MD
Delegate: Thomas Duke Kimbrough, MD
Delegate: Jeffrey S. Richards, MD
Delegate: Edward Wheeler, MD

Gonzales CMS
Delegate: Humberto J. Rivas, MD
Alternate: Terry Fuller Eska, MD

Hale-Floyd-Briscoe CMS
Delegate: Jessica Clifton Charest, MD
Alternate: Hima Bindu Jyothi, MD
Alternate: Travis G. King, MD

Harris CMS
Delegate: Audrey E. Ahuero, MD
Delegate: Jessica A. Alexander, MD
Delegate: Raymond T. Alexander, MD
Delegate: Ronda E. Alexander, MD
Delegate: Paul M. Allison, MD
Delegate: Robert L. Arkus, MD
Delegate: Syed K. Azeemuddin, MD
Delegate: Martin Basaldua, MD
Delegate: Janette K. Bateman, MD
Delegate: H. S. Bedi, MD

Harris CMS (continued)
Delegate: Lindsay K. Botsford, MD
Delegate: Richard N. Bradley, MD
Delegate: Brian M. Bruel, MD
Delegate: Lucy A. Buencamino, MD
Delegate: Sudipta K. Chaudhuri, DO
Delegate: Charles E. Cowles Jr., MD
Delegate: Steven M. Croft, 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: Arthur Garson Jr., MD
Delegate: Marina C. George, MD
Delegate: Bernard M. Gerber, MD
Delegate: Alan P. Glombicki, MD
Delegate: James S. Guo, MD
Delegate: Leslie M. Haber, MD
Delegate: Steven E. Haber, MD
Delegate: Alison J. Haddock, MD
Delegate: Ori Z. Hampel, MD
Delegate: Shannon B. Hancher-Hodges, MD
Delegate: 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: 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
Delegate: Paul Martin Mauk, MD
Delegate: Jaideep H. Mehta, MD
Delegate: Kimberly E. Monday, MD
Delegate: Robert B. Morrow, MD, MBA
Delegate: Lonzetta L. Newman, MD
Delegate: Mark L. Nichols, MD
Delegate: Richard L. Noel, MD
Delegate: Stacy L. Norrell, MD
Delegate: Carla F. Ortique, MD

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

Harris CMS (continued)

Delegate:	Debra M. Osterman, MD
Delegate:	Bradford S. Patt, MD
Delegate:	Eddie L. Patton, Jr., MD
Delegate:	Evan G. Pivalizza, MD
Delegate:	Anne Marie Ponce De Leon, MD
Delegate:	Elizabeth M. Rebello, MD
Delegate:	Edward R. Rensimer, MD
Delegate:	Carlos E. Romero, MD
Delegate:	Susan N. Rossmann, MD
Delegate:	Manish Rungta, MD
Delegate:	George D. Santos, MD
Delegate:	Umair A. Shah, MD
Delegate:	Amber D. Shamburger, MD
Delegate:	Gary J. Sheppard, MD
Delegate:	Angela Siler-Fisher, MD
Delegate:	Mina K. Sinacori, MD
Delegate:	Alan W. Skolnick, MD
Delegate:	Charles E. Soderstrom, MD
Delegate:	Charlotte M. Stelly-Seitz, MD
Delegate:	Richard Strax, MD
Delegate:	Angela K. Sturm, MD
Delegate:	Spencer H. Su, MD
Delegate:	Irvin Sulapas, MD
Delegate:	Sarah L. Svoboda, MD
Delegate:	Arthur L. Taitel, MD
Delegate:	Rosa A. Tang, MD
Delegate:	Dexter G. Turnquest, MD
Delegate:	Robert C. Vanzant, MD
Delegate:	Carlos J. Vital, MD
Delegate:	Ronald S. Walters, MD
Delegate:	Stephen E. Whitney, MD
Delegate:	George W. Williams II, MD
Delegate:	Kevin Scott Winfield, MD, MBA
Alternate:	Madhureeta Achari, MD
Alternate:	Rehan Ahmed, MD
Alternate:	Asif Ali, MD
Alternate:	Asra Ali, MD
Alternate:	Anna M. Allred, MD
Alternate:	Jaya S. Amaram-Davila, MD
Alternate:	Kulvinder S. Bajwa, MD
Alternate:	Luis H. Camacho, MD
Alternate:	Ellia Ciammaichella, DO
Alternate:	Donald R. Collins Jr., MD
Alternate:	Tamyra Y. Comeaux, MD
Alternate:	Stacey L. Coombes, MD
Alternate:	Anh Q. Dang, MD
Alternate:	Lilette E. Daumas-Britsch, MD
Alternate:	Emma L. Dishner, MD
Alternate:	Troy T. Fiesinger, MD
Alternate:	Etai Funk, MD
Alternate:	Clare N. Gentry, MD
Alternate:	Noel M. Giesecke, MD

Harris CMS (continued)

Alternate:	P. Ridgway Gilmer Jr., MD
Alternate:	Sara Goel, DO
Alternate:	Angela M. Guerra, MD
Alternate:	Arafat A. Hashwani, MD
Alternate:	Gabrielle E. Hatton, MD
Alternate:	Eric J. Haufrect, MD
Alternate:	Nicky R. Holdeman, MD
Alternate:	David R. Hoyer Jr., MD
Alternate:	Ifeyinwa C. Ifeanyi-Pillette, MD
Alternate:	Laura P. Jimenez-Quintero, MD
Alternate:	Binal S. Kancherla, MD
Alternate:	Ahmed O. Kaseb, MD
Alternate:	Russell W. H. Kridel, MD
Alternate:	Gus W. Krucke, MD
Alternate:	Ana L. Leech, MD
Alternate:	Andrew Li-Yung Hing, MD
Alternate:	Shane M. Magee, MD
Alternate:	Suzanne M. Manzi, MD
Alternate:	Anna L. C. Mapp, MD
Alternate:	Ankur D. Mehta, DO
Alternate:	Murtaza Mussaji, DO
Alternate:	Santhosshi Narayanan, MD
Alternate:	Vincent G. Nelson, MD
Alternate:	Rupesh Nigam, MD
Alternate:	Kehinde O. Ogunmakin, MD
Alternate:	Thomas J. Oliverson, MD
Alternate:	Thomas J. Parr, MD
Alternate:	Madhavi Patnana, MD
Alternate:	Autumn L. Pruette, MD
Alternate:	Regina E. Rodman, MD
Alternate:	Arindam Sarkar, MD
Alternate:	Shaina M. Sheppard, MD
Alternate:	Michael J. Snyder, MD
Alternate:	Susanna C. Spence, MD
Alternate:	Bao N. To, MD
Alternate:	Theresa Q. Tran, MD
Alternate:	January Y. Tsai, MD
Alternate:	John R. Vanderzyl, MD
Alternate:	Thomas C. Wiener, MD
Alternate:	Wendell H. Williams III, MD
Alternate:	Barbara J. Wilson, MD
Alternate:	Crystal J. Yeo, MD
Alternate:	Alisha Y. Young, MD

Harrison CMS

Delegate:	Valarie Lee Allman, MD
Alternate:	Robert W. Palmer, Sr., MD

Henderson CMS

Delegate:	Tina P. Elkins, MD
Alternate:	William Alex Elfarr, MD

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

Hidalgo-Starr CMS
- Delegate: Sarojini G. Bose, MD
- Delegate: Lenore C. DePagter, DO, MBA
- Delegate: Sandra Esquivel, MD
- Delegate: Martin Garza, MD
- Delegate: Laura Faye Gephart, MD, MBA
- Delegate: Mark Stewert Gonzalez, MD
- Delegate: Javier D. Margo Jr., MD
- Alternate: Thiendella Diagne, MD
- Alternate: Antonio Falcon, MD
- Alternate: Victor Hugo Gonzalez, MD
- Alternate: Chevy Chu Lee, MD

Hill Country CMS
- Delegate: Matthew Emanuel Stotz, MD

Hopkins-Franklin CMS
- Delegate: Martin W. Fielder, MD
- Alternate: Scott Randall McDearmont, MD

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

Jefferson CMS
- Delegate: Benjamin Wallace Beckert, MD
- Delegate: Bodo Brauer, MD
- Delegate: Vijay Kumar Krishnan, MD
- Delegate: William Ellis O'Mara Jr., MD
- Alternate: John Kerry Badlissi, MD
- Alternate: Ramzi S. Dakour, MD
- Alternate: Jurswin Coffy Pieternelle, MD
- Alternate: Wagdy S. Rizk, MD

Kerr-Bandera CMS
- Delegate: Richard B. Johnson, MD, PA

Lubbock CMS
- Delegate: Thomas A. Bowman, MD
- Delegate: Ronald Lynn Cook, DO
- Delegate: Sandra Dee Dickerson, MD
- Delegate: Jack E. DuBose, MD
- Delegate: Juan Francisco Fitz, MD
- Delegate: Lloyd Marshall Garland, MD
- Delegate: Kalarickal J. Oommen, MD
- Delegate: Karl G. Pankratz, MD
- Delegate: Eldon Stevens Robinson, MD
- Delegate: Janice Ann Stachowiak, MD
- Delegate: Davor Vugrin, MD
- Alternate: Zachary E. Ballenger, MD
- Alternate: Ryan A. Burden
- Alternate: Naidu K. Chekuru, MD
- Alternate: Sharmila D. Dissanaike, MD
- Alternate: Allan Louis Haynes Jr., MD
- Alternate: Ann C. Hughes Bass, MD
- Alternate: Sameer Islam, MD
- Alternate: Cynthia Ann Jumper, MD, MPH
- Alternate: Patti Nelson May, MD
- Alternate: Ambir R. Mirza, MD
- Alternate: Monisha Narayanan
- Alternate: Sergiy Nesterenko, MD

Lubbock CMS (continued)
- Alternate: Mario Pena Jr., MD
- Alternate: James A. Tarbox, MD
- Alternate: Surendra K. Varma, MD
- Alternate: Shiraz A. Yazdani, MD

McLennan CMS
- Delegate: Scott E. Blattman, MD
- Delegate: Bradford W. Holland, MD
- Delegate: William T. McCunniff, MD
- Delegate: Russell Scott Warren, MD
- Delegate: Robert E. Wolf, MD
- Alternate: Brian Edward Barkley, DO
- Alternate: Roland Adolph Goertz, MD, MBA
- Alternate: Clint W. McHenry, DO
- Alternate: David M. Pinkstaff, MD
- Alternate: Charles Herbert Stern, MD

Midland CMS
- Delegate: James William Huston, MD
- Delegate: Robert Allen Vogel, MD

Montgomery CMS
- Delegate: Nefertiti C. Dupont, MD
- Delegate: Ferenc Markos, MD
- Alternate: Kristie R. Chandler, MD

Nacogdoches-San Augustine CMS
- Delegate: Gerard J. Ventura, MD, FACP

Nueces CMS
- Delegate: Jack Locardi Cortese, MD
- Delegate: George H. Fisher Jr., MD
- Delegate: Albert Lee Gest, DO
- Delegate: Jerry Dean Hunsaker, MD
- Delegate: John Duncan McKeever, MD
- Delegate: Jacob J. Moore, MD
- Delegate: Mary Dahlen Peterson, MD
- Delegate: Daniel V. Vijjeswarapu, MD
- Alternate: Vijay K. Bindingnavele, MD
- Alternate: Rafael Francisco Coutin, MD
- Alternate: Meera Gangadharan, MD
- Alternate: Justin Paul Hensley, MD
- Alternate: Shah Faizul Islam, MD
- Alternate: Shaheen Karim, MD
- Alternate: Adam L. Spengler, MD

Parker CMS
- Delegate: Mark Carroll Eidson, MD

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

Smith CMS
- 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: Thomas J. Lambert Jr., MD

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

Smith CMS (continued)

Alternate:	Joseph T. Martins, MD
Alternate:	William M. McCrady, MD
Alternate:	Evans S. Smith, MD

Tarrant CMS

Delegate:	Joane G. Baumer, MD
Delegate:	David J. Donahue, MD
Delegate:	Josephine Rebecca Fowler, MD
Delegate:	Cheryl Lynn Hurd, MD
Delegate:	Woody V. Kageler, MD
Delegate:	R. Larry Marshall, MD
Delegate:	George Sealy Massingill, MD
Delegate:	Gregory J. Phillips, MD
Delegate:	Stuart C. Pickell, MD, FACP
Delegate:	Ann E. Ranelle, DO
Delegate:	Kurt A. Schoppe, MD
Delegate:	Angela D. Self, MD
Delegate:	Mark M. Shelton, MD
Delegate:	Linda M. Siy, MD
Delegate:	Joe M. Todd, MD
Alternate:	Ralph F. Baine, MD
Alternate:	Susan K. Blue, MD
Alternate:	Brett L. Cochrum, MD
Alternate:	Shanna Marie Combs, MD
Alternate:	James S. Cox, MD
Alternate:	Theresa V. Crouch, MD
Alternate:	Miguel De Valdenebro, MD
Alternate:	Michael G. Enger, MD
Alternate:	Christopher S. Ewin, MD
Alternate:	Kim E. Higgins, DO
Alternate:	Nishant B. Jalandhara, MD
Alternate:	Luis H. Martinez, MD
Alternate:	Neal J. Richmond, MD
Alternate:	Robert J. Rogers, MD
Alternate:	David F. Turbeville, MD
Alternate:	Veer D. Vithalani, MD
Alternate:	Dan A. Willis, MD
Alternate:	Michael E. Wimmer, MD

Travis CMS

Delegate:	Tony R. Aventa, MD
Delegate:	Kimberly C. Avila Edwards, MD
Delegate:	Ira Bell III, MD
Delegate:	Michelle A. Berger, MD
Delegate:	Maya B. Bledsoe, MD
Delegate:	Edward D. Buckingham, MD
Delegate:	Esther J. Cheung-Phillips, MD
Delegate:	Elizabeth L. Chmelik, MD
Delegate:	James R. Eskew, MD
Delegate:	Nancy Thorne Foster, MD
Delegate:	Vimal T. George, MD
Delegate:	Albert T. Gros, MD
Delegate:	Juan M. Guerrero, MD
Delegate:	Katharina Hathaway, MD

Travis CMS (continued)

Delegate:	Felix Hull, 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:	Harris S. Rose, MD
Delegate:	Stephanie D. Roth, MD
Delegate:	Dora L. Salazar, MD
Delegate:	Ghassan Salman, MD, MBA,
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:	Stephanie M. Vertrees, MD
Delegate:	John F. Villacis, MD
Delegate:	Stanley S. Wang, MD, JD, MPH
Delegate:	Belda Zamora, MD
Delegate:	Guadalupe Zamora, MD
Alternate:	Alexander J. Alvarez, MD
Alternate:	Lu Ann L. Bundrant, MD
Alternate:	Vineet Choudhry, MD
Alternate:	Scott W. Clitheroe, 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:	Heather M. Falvo, MD
Alternate:	Grace L. Honles, MD
Alternate:	Anand Joshi, MD
Alternate:	Gurneet Singh Kohli, MD
Alternate:	Megan K. Kressin, MD
Alternate:	Craig Allen Kuhns, MD
Alternate:	Sushmitha Kurapati, MD
Alternate:	Amanda K. LaViolette, MD, MPH
Alternate:	Anna M. Lozano, MD
Alternate:	Jonathan E. MacClements, MD
Alternate:	Marcella A. Madera, MD
Alternate:	Hector A. Miranda-Grajales, MD
Alternate:	Graves T. Owen, MD
Alternate:	Michelle C.M. Owens, DO
Alternate:	Dennis Samuel Pacl, MD
Alternate:	A. Melinda Rainey, MD
Alternate:	Fara Ranjbaran, MD
Alternate:	Halsey M. Settle III, MD
Alternate:	Koonj A. Shah, MD
Alternate:	Lynn N. Stewart, MD

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

Travis CMS (continued)
- Alternate: Brian W. Temple, MD
- Alternate: David N. Tobey Jr., MD
- Alternate: Elizabeth Truong, MD
- Alternate: Vani S. Vallabhaneni, 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
- Alternate: John David Cluley, MD
- Alternate: Cameron H. Gates, DO

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

Webb-Zapata-Jim Hogg CMS
- Delegate: Luis Manuel Benavides, MD

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 CMS
- Delegate: Kambiz Jahadi, MD
- Delegate: Matthew David Lynx, MD
- Delegate: Theodore J. Spinks, MD
- Alternate: Susan M. Pike, MD

Young CMS
- Delegate: Donald A. Behr, MD
- Alternate: Hal Davis Huffman, MD

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

VOTING EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES BY ALPHA
May 2018 (multiple voting positions are listed but member only has ONE vote)

Name	Society	Committee	Position
Bohn D. Allen, MD	Tarrant	TMA Past Presidents	Member
Anna M. Allred, MD	Harris	Young Physician Section	Delegate
Michael A. Altman, MD	Harris	TMA Board of Councilors	Councilor
Mario Rudy Anzaldua, MD	Hidalgo-Starr	TMA Board of Councilors	Councilor
Charles W. Bailey Jr., MD	Travis	TMA Past Presidents	Member
Susan Rudd Bailey, MD	Tarrant	Texas Delegation to AMA	Delegate
Susan Rudd Bailey, MD	Tarrant	TMA Past Presidents	Member
Alan C. Baum, MD	Harris	TMA Past Presidents	Member
Michelle A. Berger, MD	Travis	TMA Officers	Secretary-Treasurer
Michelle A. Berger, MD	Travis	Texas Delegation to AMA	Delegate
Phil H. Berry Jr., MD	Dallas	TMA Past Presidents	Member
Louise H. Bethea, MD	Harris	Inter-Specialty Society	Delegate
Justin M. Bishop, MD	Dallas	TMA Board of Trustees	Resident Physician Trustee
Sue Scher Bornstein, MD	Dallas	TMA Board of Trustees	Member At-Large
Keith A. Bourgeois, MD	Harris	TMA Board of Trustees	Member At-Large
Jim Bob Brame, MD	Concho Valley	TMA Past Presidents	Member
Stephen L. Brotherton, MD	Tarrant	TMA Past Presidents	Member
Adam J. Bruggeman, MD	Bexar	Inter-Specialty Society	Delegate
Ryan A. Burden	Lubbock	Medical Student Section	Delegate
Brad G. Butler, MD	Big Country	Texas Delegation to AMA	Delegate
Gerald R. Callas, MD	Jefferson	Texas Delegation to AMA	Alt. Delegate
Gerald R. Callas, MD	Jefferson	TMA Board of Trustees	Member At-Large
Carlos Javier Cardenas, MD	Hidalgo-Starr	TMA Officers	President
John T. Carlo, MD	Dallas	Council on Socioeconomics	Chair
John T. Carlo, MD	Dallas	Texas Delegation to AMA	Alt. Delegate
Mark A. Casanova, MD	Dallas	Council on Constitution and Bylaws	Chair
Tilden L. Childs III, MD	Tarrant	Inter-Specialty Society	Delegate
Gates B. Colbert, MD	Dallas	Young Physician Section	Delegate
Patrick D. Crowley	Tarrant	TMA Board of Trustees	Medical Student Trustee
Douglas W. Curran, MD	Henderson	TMA Officers	President-Elect
Carrie E. De Moor, MD	Collin-Fannin	TMA Board of Trustees	Young Physician Trustee
Donald Bryan Egan	Bexar	Medical Student Section	Delegate
Robert H. Emmick Jr., MD	Travis	Texas Delegation to AMA	Alt. Delegate
James R. Eskew, MD	Travis	TMA Board of Councilors	Councilor
Troy T. Fiesinger, MD	Harris	Inter-Specialty Society	Delegate
Diana L. Fite, MD	Harris	TMA Board of Trustees	Member At-Large
Diana L. Fite, MD	Harris	Texas Delegation to AMA	Delegate
David C. Fleeger, MD	Travis	Texas Delegation to AMA	Delegate
David C. Fleeger, MD	Travis	TMA Board of Trustees	Member At-Large
William H. Fleming III, MD	Harris	TMA Past Presidents	Member
William H. Fleming III, MD	Harris	Texas Delegation to AMA	Delegate

Name	Society	Committee	Position
John Gerard Flores, MD	Denton	Texas Delegation to AMA	Alt. Delegate
Gary W. Floyd, MD	Tarrant	TMA Board of Trustees	Member At-Large
Gary W. Floyd, MD	Tarrant	Texas Delegation to AMA	Delegate
Gregory M. Fuller, MD	Tarrant	Texas Delegation to AMA	Alt. Delegate
Jessica L. Gale	Bexar	Medical Student Section	Delegate
A. Tomas Garcia, III, MD	Harris	TMA Past Presidents	Member
Bobby J. Gerich Jr.	Harris	Medical Student Section	Delegate
John T. Gill, MD	Dallas	Texas Delegation to AMA	Delegate
William S. Gilmer, MD	Harris	Texas Delegation to AMA	Alt. Delegate
Roland A. Goertz, MD	McLennan	TMA Board of Councilors	Councilor
Victor Hugo Gonzalez, MD	Hidalgo-Starr	Council on Legislation	Member
Donald J. Gordon, MD	Bexar	TMA Board of Councilors	Councilor
Anupama Gotimukula, MD	Bexar	International Medical Graduate Section	Delegate
Michael S. Graves, MD	Travis	Inter-Specialty Society	Delegate
Jedidiah James Grisel, MD	Wichita	TMA Board of Councilors	Councilor
Gary E. Gross, MD	Smith	Inter-Specialty Society	Delegate
Robert Tau Gunby Jr., MD	Dallas	Texas Delegation to AMA	Delegate
Robert Tau Gunby Jr., MD	Dallas	TMA Past Presidents	Member
James S. Guo, MD	Harris	Council on Health Service Organizations	Chair
Alison J. Haddock, MD	Harris	Young Physician Section	Delegate
Lesca C. Hadley, MD	Johnson	Inter-Specialty Society	Delegate
Trevor D. Hadley	Harris	Medical Student Section	Delegate
Stephen Haff	Dallas	Medical Student Section	Delegate
Tom B. Hancher, MD	Colorado-Fayette	TMA Past Presidents	Member
Gilberto A. Handal, MD	El Paso	TMA Board of Councilors	Councilor
Steven Ray Hays, MD	Dallas	Council on Medical Education	Chair
Steven Ray Hays, MD	Dallas	Texas Delegation to AMA	Alt. Delegate
David Norman Henkes, MD	Bexar	TMA Board of Trustees	Member At-Large
David Norman Henkes, MD	Bexar	Texas Delegation to AMA	Delegate
William W. Hinchey, MD	Bexar	TMA Past Presidents	Member
Jessie W. Ho	Dallas	Texas Delegation to AMA	Alt. Delegate
Bradford W. Holland, MD	McLennan	Council on Legislation	Member
James Loyd Humphreys, MD	Bexar	Council on Legislation	Member
Robert E. Jackson, MD	Harris	Council on Legislation	Member
Bryan G. Johnson, MD	Collin-Fannin	Council on Legislation	Member
Gregory R. Johnson, MD	Brazoria	Council on Legislation	Member
Collin M. Juergens, MD	Bell	Resident and Fellow Section	Delegate
Cynthia Ann Jumper, MD, MPH	Lubbock	Texas Delegation to AMA	Alt. Delegate
Cynthia Ann Jumper, MD, MPH	Lubbock	Council on Legislation	Member
Jeffrey B. Kahn, MD	Travis	Inter-Specialty Society	Delegate
Thomas J. Kim, MD	Travis	Council on Legislation	Member
Austin Irvin King, MD	Big Country	TMA Past Presidents	Member
Louis John Kirk III, MD	Gregg-Upshur	TMA Board of Councilors	Councilor

Name	Society	Committee	Position
Heidi C. Knowles, MD	Anderson-Leon	Inter-Specialty Society	Delegate
Kyle Gregory Krohn, MD	Angelina	TMA Board of Councilors	Councilor
Mark J. Kubala, MD	Jefferson	TMA Past Presidents	Member
Pradeep Kumar, MD	Travis	Inter-Specialty Society	Delegate
David L. Lakey, MD	Travis	Council on Science and Public Health	Chair
David T.H. Lam	Tarrant	Medical Student Section	Delegate
Amanda K. LaViolette, MD	Travis	Inter-Specialty Society	Delegate
Benjamin C. Lee, MD	Dallas	Council on Health Promotion	Chair
Dan L. Locker, MD	Central Texas	TMA Board of Councilors	Councilor
Asa C. Lockhart, MD	Smith	Texas Delegation to AMA	Delegate
C. Bruce Malone, III, MD	Travis	TMA Past Presidents	Member
Kenneth L. Mattox, MD	Harris	Texas Delegation to AMA	Delegate
Kevin Hood McKinney, MD	Galveston	TMA Board of Councilors	Councilor
Kevin Hood McKinney, MD	Galveston	Texas Delegation to AMA	Delegate
Isabel C. Menendez, MD	San Patricio-Aransas-Refugio	Council on Legislation	Member
Sandeep G. Mistry, MD	Travis	Inter-Specialty Society	Delegate
Richard L. Noel, MD	Harris	Inter-Specialty Society	Delegate
Daniel A. Nwachokor, MD	Harris	Resident and Fellow Section	Delegate
Patrick O. Ojeaga	Hidalgo-Starr	Medical Student Section	Delegate
Nimesh H. Patel, MD	Dallas	Inter-Specialty Society	Delegate
Debra A. Patt, MD	Travis	Council on Legislation	Member
Lee Ann Pearse, MD	Dallas	Council on Legislation	Member
Charles M. Perricone, MD	Rusk	TMA Board of Councilors	Councilor
Jack W. Pierce, MD	Travis	Inter-Specialty Society	Delegate
Susan M. Pike, MD	Williamson	Inter-Specialty Society	Delegate
Evan G. Pivalizza, MD	Harris	Inter-Specialty Society	Delegate
Tucker D. Pope	Travis	Medical Student Section	Delegate
Vivek U. Rao, MD	Ector	TMA Board of Councilors	Councilor
Don Robert Read, MD	Dallas	TMA Officers	Immediate Past President
Don Robert Read, MD	Dallas	TMA Past Presidents	Member
Larry E. Reaves, MD	Tarrant	Texas Delegation to AMA	Delegate
Carlos Rizo-Patron, MD	Lubbock	TMA Board of Councilors	Councilor
J. James Rohack, MD	Galveston	TMA Past Presidents	Member
Jennifer R. Rushton, MD	Bexar	Texas Delegation to AMA	Alt. Delegate
Habeeb Munir Salameh, MD	Galveston	Texas Delegation to AMA	Alt. Delegate
Ghassan F. Salman, MD	Travis	Council on Health Care Quality	Chair
C. M. Schade, MD, PhD	Dallas	Inter-Specialty Society	Delegate
Dean Allen Schultz, MD	Big Country	Council on Practice Management Services	Chair
Leslie Harold Secrest, MD	Dallas	Texas Delegation to AMA	Delegate
Jayesh B. Shah, MD	Bexar	Texas Delegation to AMA	Alt. Delegate
Rahul Shah	Galveston	Medical Student Section	Delegate
Akaanksh Shetty	El Paso	Medical Student Section	Delegate
Victor A. Simms, MD	Harris	Council on Legislation	Member

Name	Society	Committee	Position
Gretta Smith	Brazos-Robertson	Medical Student Section	Delegate
Richard W. Snyder II, MD	Dallas	TMA Board of Trustees	Member At-Large
Michael E. Speer, MD	Harris	TMA Past Presidents	Member
V. O. Speights Jr., DO	Bell	Inter-Specialty Society	Delegate
Nicholas P. Steinour, MD	McLennan	Young Physician Section	Delegate
Susan M. Strate, MD	Wichita	TMA Officers	Speaker
Robert Mayo Tenery Jr., MD	Dallas	TMA Past Presidents	Member
Jason V. Terk, MD	Tarrant	Council on Legislation	Member
John J. Thoppil, MD	Travis	Inter-Specialty Society	Delegate
Lyle S. Thorstenson, MD	Dallas	Texas Delegation to AMA	Delegate
Elizabeth Torres, MD	Harris	Texas Delegation to AMA	Alt. Delegate
Edward Wilmar Tuthill, MD	Dallas	TMA Board of Councilors	Councilor
Roxanne Marie Tyroch, MD	El Paso	Council on Legislation	Member
Roxanne Marie Tyroch, MD	El Paso	Texas Delegation to AMA	Alt. Delegate
Ryan D. Van Ramshorst, MD	Bexar	Inter-Specialty Society	Delegate
David Vanderpool, MD	Dallas	TMA Past Presidents	Member
E. Linda Villarreal, MD	Hidalgo-Starr	TMA Board of Trustees	Member At-Large
E. Linda Villarreal, MD	Hidalgo-Starr	Texas Delegation to AMA	Delegate
Stanley S. Wang, MD	Travis	Inter-Specialty Society	Delegate
Arlo F. Weltge, MD	Harris	Texas Delegation to AMA	Alt. Delegate
Arlo F. Weltge, MD	Harris	TMA Officers	Vice Speaker
Sara A. Westgate, MD	Travis	Inter-Specialty Society	Delegate
Andrew J. Widmer, MD	Bell	Resident and Fellow Section	Delegate
Kristin A. Wong, MD	Travis	Inter-Specialty Society	Delegate
Sherif Z. Zaafran, MD	Harris	Texas Delegation to AMA	Alt. Delegate
Gabriela M. Zandomeni, MD	Dallas	Young Physician Section	Delegate
Yasser Fahmy Zeid, MD	Gregg-Upshur	Council on Legislation	Member

Revised for Supplement

ELECTIONS
May 2018

OFFICERS

Office	Incumbent	Eligible for Election	Term of Position	Candidates Announced as of May 1
President-Elect	Douglas W. Curran	No	2018-19	David C. Fleeger* Travis
Speaker, House of Delegates	Susan M. Strate	Yes	2018-19	Susan M. Strate Wichita
Vice Speaker, House of Delegates	Arlo F. Weltge	Yes	2018-19	Arlo F. Weltge Harris
Three Trustees**	David N. Henkes Keith A. Bourgeois Richard W. Snyder	No Yes Yes	2018-21	Keith A. Bourgeois Harris Carrie de Moor Collin-Fannin Jayesh B. Shah Bexar Richard W. Snyder Dallas Joseph S. Valenti Denton
Board of Trustees Young Physician Member	Carrie de Moor	No	2018-20	Lindsay Botsford Harris

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

House policy also provides that the names of candidates seeking election or reelection be distributed in advance. However, nominations will be accepted on the floor of the house whether or not prior notification of intent to seek election has been received or published.

If you wish to announce your candidacy or a candidate for election or reelection, please notify Ada Drozd, executive coordinator, Office of the EVP, at ada.drozd@texmed.org or (800) 880-1300, ext. 1540.

*Should Dr. Fleeger be elected president-elect, four trustees will be elected.

**Trustee positions are "at large," not slotted. TMA Bylaws provide that all nominees for trustee will be listed on a single ballot.

Revised for Supplement

COUNCILOR AND VICE COUNCILOR ELECTIONS
May 2018

COUNCILORS

Office	Incumbent	Eligible for Election	Term of Position	Candidates Announced as of May 1
District 1	Gilbert A. Handal	Yes	2018-21	Gilbert A. Handal
District 2	Vivek U. Rao	Yes	2018-21	Vivek U. Rao
District 4	Dan L. Locker	No	2018-21	Jane C. Rider
District 11	Charles M. Perricone	No	2018-21	Sheldon Y. Freeberg
District 14	Edward W. Tuthill	Yes	2018-21	Edward W. Tuthill

VICE COUNCILORS*

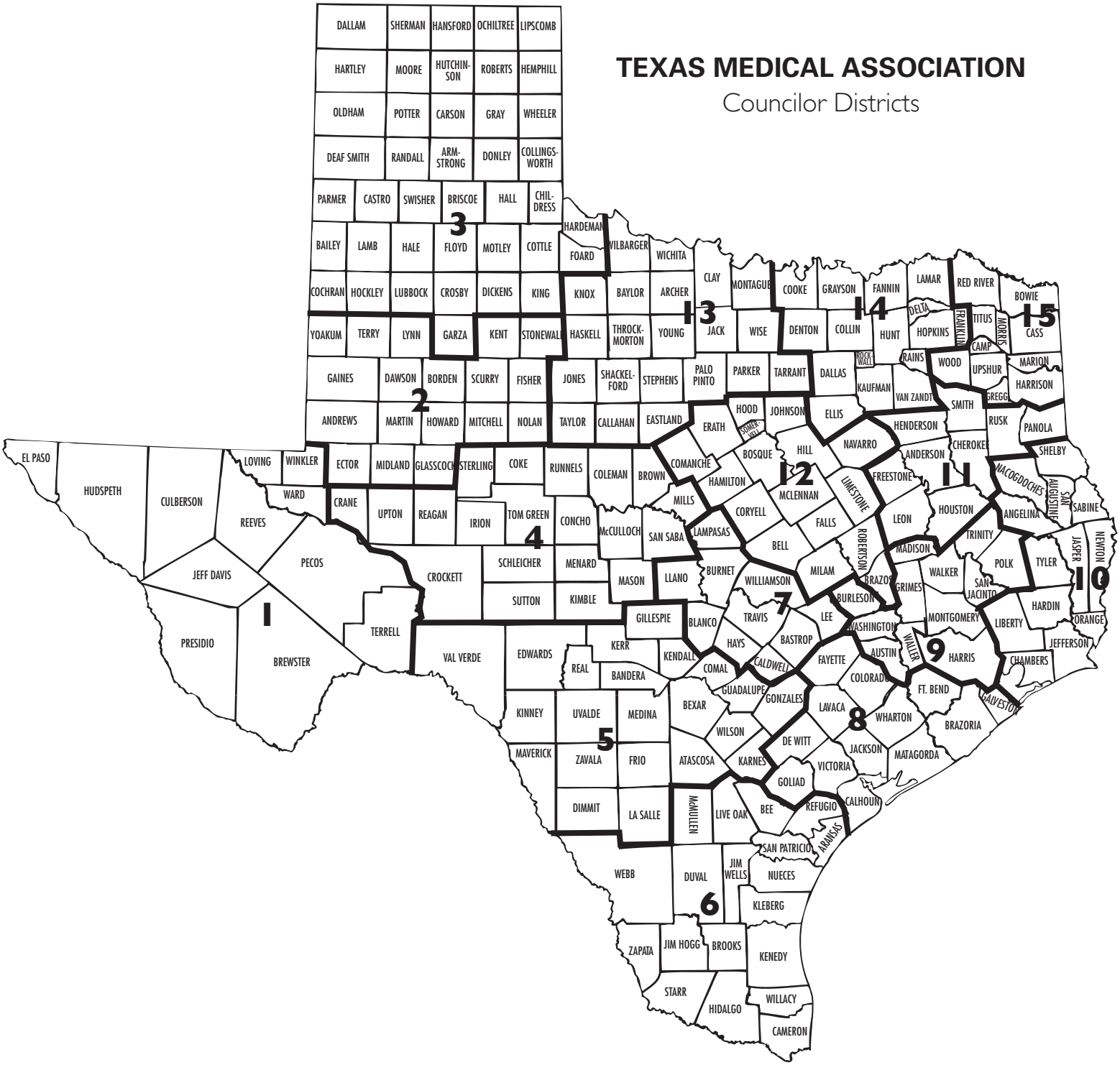
Office	Incumbent	Eligible for Election	Term of Position	Candidates Announced as of May 1
District 2	James W. Huston	Yes	2018-21	James W. Huston
District 4	Jane C. Rider	No	2018-21	
District 11	Sheldon Y. Freeberg	No	2018-21	
District 12	Vacant		2018-19	Alisa Marie D. Berger
District 14	Victor L. Vines	Yes	2018-21	Victor L. Vines

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

*As provided in TMA Bylaws, nominations for vice councilor positions are determined by district elections and confirmed by the House of Delegates. Should you have a nomination for vice councilor, please notify Ann Arnett, assistant to the Board of Councilors, at ann.arnett@texmed.org or (800) 880-1300, ext. 1340.

TEXAS MEDICAL ASSOCIATION

Councilor Districts



Revised for Supplement

AMA DELEGATION ELECTIONS
May 2018

DELEGATES

Delegates	Incumbent	Eligible for Reelection	Term (2 Years) Jan. 1-Dec. 31	Candidates Announced as of May 1
1	Michelle A. Berger	Yes	2019-20	Michelle A. Berger
2	Brad G. Butler	Yes	2019-20	Brad G. Butler
3	David C. Fleeger	Yes	2019-20	David C. Fleeger
4	William H. Fleming III	Yes	2019-20	William H. Fleming III
5	Asa C. Lockhart	Yes	2019-20	Asa C. Lockhart
6	Kenneth L. Mattox	Yes	2019-20	Kenneth L. Mattox
7	Kevin H. McKinney	Yes	2019-20	Kevin H. McKinney
8	Larry E. Reaves	Yes	2019-20	Larry E. Reaves
9	Leslie H. Secrest	Yes	2019-20	Leslie H. Secrest
10	E. Linda Villarreal	Yes	2019-20	E. Linda Villarreal

ALTERNATE DELEGATES

Alternate Delegates	Incumbent	Eligible for Reelection	Term (2 Years) Jan. 1-Dec. 31	Candidates Announced as of May 1
1	Vacancy		2019-20	Laura Faye Gephart Alexander Kenton
2	G. Ray Callas	Yes	2019-20	G. Ray Callas
3	Gregory M. Fuller	Yes	2019-20	Gregory M. Fuller
4	William S. Gilmer	Yes	2019-20	William S. Gilmer
5	Cynthia A. Jumper	Yes	2019-20	Cynthia A. Jumper
6	Elizabeth Torres	Yes	2019-20	Elizabeth Torres
7	Roxanne M. Tyroch	Yes	2019-20	Roxanne M. Tyroch
8	Arlo F. Weltge	Yes	2019-20	Arlo F. Weltge
9	Habeeb M. Salameh*	No	2018-19	Theresa Phan
10	Jessie Ho*	No	2018-19	Faith Mason

Delegates and alternate delegates serve two-year terms, Jan. 1, 2019-Dec. 31, 2020; except that the terms for alternate delegate Places 9 and 10, which are designated for a resident and medical student, are May 19, 2018-May 18, 2019.

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

Name: _____
(Please Print)

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.

   _____

   _____

Approved by the Board of Trustees June 2005
Amended by the Board of Trustees Aug. 2006, Sept. 2008, Sept. 2009, Jan. 2011 and Dec. 2017

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

No: _____

Yes: _____

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

_____

_____

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

No: _____

Yes: _____

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

_____

_____

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

No: _____

Yes: _____

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

_____

_____

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

No: _____

Yes: _____

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

_____

_____

Statement of Compliance with the Conflicts of Interest Policy

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

Printed name: _____

Date: _____ Signature: _____

ATTACHMENT A

RELATED ENTITIES

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

- **TEXAS MEDICAL ASSOCIATION LIBRARY** dba **TMA KNOWLEDGE CENTER**
  - Ervin E. and Gertrude K. Baden Trust (Baden fund)
- **TEXAS MEDICAL ASSOCIATION SPECIAL FUNDS FOUNDATION**
  - Durham Endowment
  - Durham Student Loan Fund
  - Harriet Cunningham Memorial Graduate Fellowship in Medical Writing
  - Medical Student Loan Fund
  - Harris County Medical Society Alliance Scholarship Fund
  - Overton Annual Lectureship
  - Young Physician Section Rural Student Scholarship Fund
  - TMA Minority Scholarship Program
  - Patricia Lee Palmer, MD, Memorial Resident Loan Fund
  - directed public health and educational program funds
  - History of Medicine fund
  - Texas Medical Association Alliance Student Loan Fund

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

- **TMA PRACTICE EDGE, LLC**
  The TMA Board of Trustees designates four of the seven Board of Managers members.
- **TMA PRACTICE MANAGEMENT HOLDINGS, LLC**
  The TMA Board of Trustees selects two managers, an Office of TMA and the TMA CEO.
  TMA SPECIALTY SERVICES, LLC
  The TMA Board of Trustees selects seven Board of Managers, including the TMA CEO.

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 IRREVOCABLE TRUST**

President-Elect

(Vote for one)

David C. Fleeger, MD

On behalf of the Travis County Medical Society, we are proud to nominate David C. Fleeger, MD, for president-elect of the Texas Medical Association.

Dr. Fleeger's commitment to TMA began in 1992 in the Young Physician Section (YPS) where he was the YPS delegate to the American Medical Association and chair of the section for two of his seven years on its Governing Council. His continued service to TMA has included membership on the Ad Hoc Committee on Health Care Reform, chair of the Committee on Physician Distribution and Health Care Access, and chair of the Council on Practice Management Services. He was instrumental in the development of TMA PracticeEdge and currently serves as secretary/treasurer of its Board of Managers. Dr. Fleeger is a TMA delegate to the American Medical Association and serves on the TMA Board of Trustees and its Executive and Investments committees, and is vice chair of the board.

Dr. Fleeger is a gubernatorial appointee, since 2008, to the governing board of the Texas Health Services Authority, which promotes and coordinates health information exchange and health information technology throughout the state. In 2016, he was named the presiding officer by Gov. Greg Abbott. Involvement with TMF Health Quality Institute is also a part of Dr. Fleeger's contribution to Texas medicine; he serves as chair of its Board of Trustees and on the Board of Trustees of C2C Innovative Solutions, a Medicare qualified contractor. Dr. Fleeger was awarded TMF's Philip R. Overton Award for Meritorious Service.

A past president of both the Travis County Medical Society and the Texas Society of Colon and Rectal Surgeons, Dr. Fleeger also served on the board of the Central Texas Regional Blood and Tissue Center and is a past president of the Central Texas Catholic Healthcare Guild.

St. David's Healthcare selected Dr. Fleeger to receive its Frist Humanitarian Award in recognition of his (and his wife, Jamie's) annual commitment to medical mission work in Guatemala for more than 15 years. He was elected chief of staff of St. David's Medical Center, a 500-bed facility with 1,700 medical staff members, and also served on its Board of Trustees. In 2012, the Travis County Medical Society named Dr. Fleeger Physician of the Year.

As a board certified colon and rectal surgeon and managing partner of his seven-member group practice, Dr. Fleeger is well aware of the challenges facing the physicians of Texas. We strongly encourage your support and your vote in electing David Fleeger, MD, as 2018 president-elect of TMA.

Personal Statement: *"Our TMA is arguably the strongest medical association in the country. We have accomplished this by being responsive to our physicians' needs and delivering value for the members' dues dollars. As we face the many challenges ahead of us, it remains imperative that we continue unwavering focus on the needs of Texas physicians ... no matter their specialty, location, mode of practice, gender, or age. That has always been and will always be my objective for our association."*

PROFILE

Name: David C. Fleeger, MD
Specialty: Colon and Rectal Surgery
Medical School and Post Graduate Education (with years): Texas A&M College of Medicine, 1985
Residency Program:

- Mayo Graduate School of Medicine, Rochester, MN, General Surgery (1985-1990)
- Louisiana State University-Schumpert Medical Center; CRS (1990-1991)

Board Certification(s): American Board of Colon and Rectal Surgery (recertified 2016, MOC current)
Primary Residence (City, State): Austin, TX
What is your current practice status? Check all that apply and provide percentages:

Direct Patient Care: solo, small group, or shared overhead	100%

Primary Employer and Employment Location (city, state): Austin, TX
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas. No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses.

TMF Health Quality Institute; C2C Solutions

Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?

<u>Current</u>

- Board of Trustees; Vice Chair, Investments Committee, Executive Committee, Compensation Committee, TMA/TMLT Liaison Committee, TMA/TOMA/TMF Liaison Committee
- TMA PracticeEdge; Board of Managers, Secretary/Treasurer
- AMA Delegation; Delegate, Delegation Affairs Committee
- TEXPAC; Capitol Club Member
- TMA Foundation; Leadership Society

<u>Past</u>

- Young Physicians Section; Governing Council, Delegate to AMA, Chair
- Committee on Physician Distribution and Health Care Access; Chair
- Council on Practice Management Services; Chair
- Ad Hoc Committee on Health Care Reform
- House of Delegates; Delegate, Reference Committee
- AMA Delegation; Awards Committee
- Council on Health Care Quality
- Medical Services Organization Steering Committee; Chair
- Board of Trustees; Secretary
- TEXPAC; District 14 Vice Chair

DISCLOSURE OF AFFILIATIONS

- Bailey Square Surgery Center
- Central Texas Colon & Rectal Surgeons
- Texas Health Services Authority
- Texas Medical Association PracticeEdge, LLC
- Surgicare of South Austin

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

Name: Susan M. Strate, MD
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	100%

Primary Employer and 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?

<u>Current</u>

- 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

<u>Past</u>

- 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

Vice Speaker, House of Delegates

(Vote for one)

Arlo F. Weltge, MD

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 House of Delegates web site, improved web access to TMA policies, and transition to the new AIP Parliamentary authority.

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

Dr. Weltge is a board-certified emergency physician in full-time clinical practice for 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

Name: Arlo F. Weltge, MD
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
What is your current practice status? Check all that apply and provide percentages:

Academic (60% clinical)	100%

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:

- University of Texas Medical School, Houston, Clinical Professor
- Houston Community College Program in EMS, Medical Director
- American Medical Response EMS Service, Houston Operations
- Occasional review for medical defense law firms for TMB and medical legal cases (no 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
- Officer, TEXPAC Board of Directors and Executive Committee
- Chair and member, TEXPAC Candidate Evaluation Cmte & TEXPAC Membership Cmte
- 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 & 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)

Board of Trustees

(Vote for three)

Keith A. Bourgeois, MD

The Harris County Medical Society is honored to endorse the candidacy of Keith A. Bourgeois, MD, for reelection to the TMA Board of Trustees.

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

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

A past president of the Texas Ophthalmological Association and of the Harris County Medical Society, Dr. Bourgeois has been in private practice since 1988. His main office in downtown Houston is a two-person ophthalmology practice specializing in diseases and surgery of the retina and vitreous. To address the physician shortage before tort reform, he and his partner treated patients in the Rio Grande Valley, as well as in the Beaumont and Conroe areas, from 1992 to 2001. Following on that tradition of addressing the need for a retina specialist in a rural community, he also has been treating patients at a satellite office in Columbus for the past 24 years.

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

In short, Dr. Bourgeois' vast experience in medical issues that affect all physicians across the state makes him a valuable member of the TMA Board of Trustees. His ability to evaluate issue positions and understand their impact on both urban and rural as well as on small-practice or hospital-based physicians will be a critical asset to the board's decisionmaking in the years to come.

Personal Statement: *"If you honor me with reelection, I plan to dedicate my next term on the TMA Board of Trustees to preserving the sanctity of clinical autonomy and thus protecting the essence of confidence that is the foundation of the patient-physician relationship."*

PROFILE

Name: Keith A. Bourgeois, MD
Specialty: Ophthalmology-Retina and Vitreous
Medical School and Post Graduate Education (with years)
Louisiana State University, New Orleans, 1979-1983
Residency Program:

- Internship, Louisiana State University, Lafayette, LA
- Residency, The University of Texas Health Science Center at Houston (UTHSC)
- Fellowship in retina, UTHSC-Houston

Board Certification(s): American Board of Ophthalmology
Primary Residence (City, State): Houston, TX
What is your current practice status? Check all that apply and provide percentages:

Direct Patient Care: solo, small group, or shared overhead	100%

Primary Employer and Employment Location (city, state)
Keith A. Bourgeois, MD, PA, Houston, TX
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas. No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses.

- St. Joseph Medical Center, Houston, TX
- Texas Medical Liability Trust
- Occasional review of medical records for various law firms

Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
<u>Current</u>

- Member, Board of Trustees
- Ex Officio Member, TMA House of Delegates

<u>Past</u>

- District Chair, TEXPAC Board of Directors
- District Vice Chair, TEXPAC Board of Directors
- Member, Council on Legislation
- Chair, Council on Socioeconomics
- Member, Council on Socioeconomics
- Program Chair, TexMed CME Program

DISCLOSURE OF AFFILIATIONS

- Keith A. Bourgeois, MD, PA – DBA Downtown Eye Associates
- St. Joseph Medical Center, Houston, Texas
- Texas Medical Liability Trust

Board of Trustees

(Vote for three)

Carrie de Moor, MD

The Collin-Fannin County Medical Society (CFCMS) enthusiastically nominates and endorses its immediate past president, Carrie de Moor, MD, FACEP, for TMA Board of Trustees member at large.

It has been said that leadership does not come from age or doing great things, nor is it necessarily a by-product of experience. Leadership expresses itself mostly in those who get the right people to do great things. CFCMS, the TMA Young Physician Section (YPS), and even the TMA Board of Trustees itself have entrusted Dr. de Moor as a leader. First as a board member, a president, and a section leader and currently as the YPS representative on the TMA Board of Trustees, Dr. de Moor has proven her ability to engage fellow physicians, both young and old, to advocate for the future of medicine.

Dr. de Moor completed an internship in pediatrics at The University of Texas Medical Branch at Galveston before entering her emergency medicine residency at Texas Tech University Health Sciences Center-El Paso, where she graduated as chief resident. She is board certified by the American Board of Emergency Medicine and practices clinical medicine full time, while also acting as chief executive officer and managing partner of her large group practice throughout north central and south Texas.

Dr. de Moor has been a bold leader and a fierce advocate for the independent practice of medicine. She has served the Texas College of Emergency Physicians on its Board of Directors, as its secretary, and as delegate to the American College of Emergency Physicians (ACEP) Council. She currently serves as president of the ACEP Freestanding Emergency Centers Section and secretary of the American Association of Women Emergency Physicians. Dr. de Moor also has served the House of Medicine diligently as a delegate for CFCMS for the past nine years. She served as president of CCFMS from 2015 to 2017.

Dr. de Moor has devoted a large amount of time to advocacy in medicine; she has proven herself a leader. She rose quickly in operational leadership and served as medical director of the John Peter Smith Hospital Emergency Department, spending numerous years training residents in emergency medicine. She also pursued her passion as an entrepreneur and desire to promote the private practice of emergency medicine, and in 2013, founded Code 3 Emergency Physicians, which now has more than 120 emergency medicine physicians throughout Texas and Nevada. Dr. de Moor is well versed in practice management, insurance contract negotiations, and operational efficiency. She fights for her patients and her colleagues on the front lines of medicine daily.

Personal Statement: *"I believe that we are in a critical time for medicine and that our willingness to stand boldly in defense of the House of Medicine is absolutely crucial. Physicians, young and old, MUST engage themselves on the front lines of advocacy and fight for our future, today. I believe that I maintain the skill set and experience to help continue to lead Texas doctors during this time and to provide fresh ideas for the future of TMA via its Board of Trustees!"*

PROFILE

Name: Carrie de Moor, MD
Specialty: Emergency medicine
Medical School (with year graduated): Texas Tech University Health Sciences Center (TTUHSC), 2005, and The University of Texas Medical Branch at Galveston — Pediatrics Internship, 2006
Residency Program: TTUHSC-El Paso/Thomason Hospital
Board Certifications(s): American Board of Emergency Medicine
Primary Residence (City, State): Frisco, Texas
What is your current practice status? Check all that apply and provide percentages:

Direct Patient Care: large group practice (over 20 members)	80%
Administrative: government, health plan, or health-related, but no **direct** patient care	20%

Primary Employer and Employment Location (city, state): Code 3 Emergency Partners, LLC — Frisco, TX
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas. No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses: Code 3 Emergency Partners, LLC
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?

Current

- Board of Trustees, Young Physician Section
- Delegate, TMA House of Delegates

Past

- Member, TMA Council on Practice Management
- Immediate past chair, TMA Young Physician Section
- Chair, TMA YPS Section
- Chair-Elect, TMA YPS Section

DISCLOSURE OF AFFILIATIONS

- American College of Emergency Physicians
- Code 3 Emergency Partners
- Code 3 Emergency Physicians
- National Association of Freestanding Emergency Centers
- Texas Association of Freestanding Emergency Centers
- Texas College of Emergency Physicians
- Texas Medical Liability Trust

Board of Trustees

(Vote for three)

Jayesh (Jay) Shah, MD

The Bexar County Medical Society (BCMS) is proud to nominate one of its outstanding leaders, Jayesh (Jay) Shah, MD, for at-large member of the TMA Board of Trustees.

With the unprecedented challenges affecting medicine, TMA needs a strong leader like Dr. Shah, a collaborative and innovation-driven physician-executive leader who has led physicians in hospitals, group practice, and nonprofit physician organizations both locally and nationally. He is a past president of the American Association of Physicians of Indian Origin, a national organization representing 100,000 physicians; past chair of the American College of Clinical Wound Specialists; and current president of the American College of Hyperbaric Medicine. Dr. Shah also was president of the Bexar County Medical Society and of the Texas Indo-American Physician Society.

Dr. Shah received a bachelor of medicine, bachelor of surgery degree from Baroda Medical College, India, and completed an internal medicine residency at St. Luke's/Roosevelt Hospital (Columbia University). He is about to graduate from the master of health care administration program at Trinity University. Dr. Shah is board certified in internal medicine and in undersea and hyperbaric medicine.

Dr. Shah has been a TMA member since 2000, and is currently a TMA delegate to AMA. He served three years as a member of the TMA Council on Health Services, six years on the Membership Committee, and three years on the Ad Hoc Committee on Medicaid, CHIP, and the Uninsured. He also has served as vice chair for TEXPAC District 21. He presently serves on the Council on Health Promotion and is a co-chair of the 2018 TMA Foundation gala. Dr. Shah has served as chair of the International Medical Graduate Section for both TMA and AMA and is a long-standing BCMS delegate to TMA, currently serving as chair of the BCMS delegation.

Dr. Shah is a thought leader and educator in the field of wound care and hyperbaric medicine, having published two books, *The Textbook of Chronic Wound Care* and *Wound Care Certification Study Guide*. He is an adjunct faculty member at UT Health San Antonio and the University of the Incarnate Word (UIW) School of Medicine in San Antonio. Dr. Shah has received numerous awards not only in academia but also for his community service and leadership.

Dr. Shah is an actively practicing physician with sound business knowledge who understands the issues, can provide novel solutions, and is an advocate for Texas physicians to keep the private practice of medicine alive. He is the right prescription for the TMA Board of Trustees.

Personal Statement: "*I spend a majority of my time seeing patients on a full-time basis. I manage a small group practice, teach at UIW, and am about to graduate with a master of health care administration degree from Trinity University. I am familiar with the issues faced by Texas physicians; I deal with those issues everyday and personally believe that I can provide novel solutions for our unprecedented challenges."*

PROFILE

Name: Jayesh B. Shah
Specialty: Internal Medicine, Wound Care, Undersea and Hyperbaric Medicine
Medical School and Post Graduate Education (with years): Baroda Medical College, M.S. University, Baroda, India (1986-1992)
Residency Program: Columbia University/ St. Luke's/ Roosevelt Hospital, New York (1993-1996)
Board Certification(s): American Board of Internal Medicine; American Board of Preventive Medicine (Undersea and Hyperbaric Medicine)
Primary Residence (City, State): San Antonio, Texas
What is your current practice status? Check all that apply and provide percentages:

Direct Patient Care: solo, small group, or shared overhead	90%
Direct Patient Care: non-profit corporation [formerly 5.01(A) corporation]	5%
Administrative: government, health plan, or health-related, but no direct patient care	5%

Primary Employer and Employment Location (city, state): Self Employed at South Texas Wound Associates, PA, San Antonio, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas. No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses. International ATMO, Acelity, Tenet
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?

Current

- Texas Delegation to the AMA, Delegate
- TMA Foundation Leadership, Member
- TMA House of Delegates, Delegate
- Council on Health Promotions, Member
- TMA Foundation, Gala Co-Chair

Past

- International Medical Graduates Section, Chair, Vice Chair, Member and Delegate to the TMA HOD
- TEXPAC, District Vice Chair
- Health Services Organization, Member
- Committee on Membership, Member
- Ad Hoc Committee on Medicaid, CHIP and the Uninsured, Member
- Texas Delegation to the AMA, Alternate Delegate

DISCLOSURE OF AFFILIATIONS

- President, South Texas Wound Associates, PA
- President, TIMEO2 Healing Concepts, LLC
- Physician Advisor, Mission Trail Baptist Hospital/Tenet, San Antonio, TX
- President, American College of Hyperbaric Medicine
- Member, Wound Care Alliance

Board of Trustees

(Vote for three)

Rick Snyder, MD

The Dallas County Medical Society (DCMS) is pleased to announce the candidacy of Rick Snyder, MD, for reelection to the TMA Board of Trustees. Dr. Snyder is a leader in organized medicine.

After graduating with honors from the University of Notre Dame, Dr. Snyder earned his medical degree from The University of Texas Southwestern Medical School, where he completed his residency in internal medicine and fellowship in cardiology. He formerly was a member of the Southwestern Medical Foundation Board.

Board certified in cardiovascular disease, interventional cardiology, advanced heart failure, and transplant cardiology, Dr. Snyder has practiced at Medical City Dallas Hospital since 1996, where he has served as the Department of Medicine chair, medical staff president, and Board of Trustees member. He currently is vice president of HeartPlace, the largest independent cardiology group in the state and the second largest in the country. He also represents HeartPlace in the ASPEN Physician Network, PLLC — a clinically integrated network of large, independent specialty groups serving North Texas — serving as chair of its board.

Dr. Snyder is relentless in his efforts to protect physicians and their patients through his work with DCMS, TMA, specialty societies, and the Dallas community. He believes physicians must advocate actively for their patients. Over the years, he and his wife, Shelley Hall, MD, have hosted numerous fundraisers in their home on behalf of TEXPAC for political candidates and officeholders, including four events this past fall. While DCMS president in 2012, Dr. Snyder led the physician response to the West Nile virus epidemic. His president's pages in *Dallas Medical Journal* were popular and thought-provoking.

At DCMS, Dr. Snyder has chaired the Legislative Affairs Committee and served on the board of HealthPAC, the DCMS political action committee. He has been a DCMS delegate to TMA since 2005 and serves on the Community Emergency Response Committee. At TMA, Dr. Snyder has served on the Council on Legislation, the TEXPAC Board of Directors, and many committees. He currently serves as secretary/treasurer of the newly formed TMA Integrated Solutions, LLC.

Within the American College of Cardiology (ACC), he served on its Board of Governors and Quality Strategic Directions Committee, and is on the Board of Directors for ACCPAC. He's been president of the Texas Chapter for three years and chairs the Legislative Committee. He has served as a reviewer for the American College of Cardiology/American Heart Association angioplasty and myocardial infarction guidelines.

Personal Statement: *"The classic vision of a doctor advocating for our patients must be more than words. It needs to be an essential element of who and what we are. As physicians, we can have as much impact on the care our patients receive through our work in legislative chambers, board rooms, and regulators' offices, as in exam rooms and operating rooms. As clinicians, we treat one patient at a time, but as physician advocates, we can help treat everyone all at once. I want to help everyone all at once."*

PROFILE

Name: Rick Snyder, MD
Specialty: Cardiology
Medical School and Post Graduate Education (with years): The University of Texas Southwestern Medical School (UT Southwestern), 1983-87
Residency Program:

- Parkland Memorial Hospital, UT Southwestern, 1987-90
- Fellowship, Parkland Memorial Hospital, UT Southwestern, 1990-93

Board Certification(s): Cardiovascular Disease; Interventional Cardiology, Advanced Heart Failure and Transplant Cardiology
Primary Residence (City, State): Dallas, TX
What is your current practice status? Check all that apply and provide percentages:

Direct Patient Care: large group practice (over 20 members)	100%

Primary Employer and Employment Location (city, state): HeartPlace, PA, Dallas, TX
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas. No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses. N/A
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?

<u>Current</u>

- Delegate to the Texas Medical Association
- Secretary/Treasurer TMA Specialty Services, LLC
- Member, TMA Board of Trustees

<u>Past</u>

- Member, Council on Legislation & COL Ad Hoc Committee on Transparency
- District chair, and District vice chair, TEXPAC Board of Directors
- Member, Interspecialty Society Committee
- Member, Council of Socioeconomics Ad Hoc Committee on Accountable Care Organizations
- Alternate Delegate to the Texas Medical Association
- Member Ad Hoc Committee on Insurance and Managed Care
- Member, Ad Hoc Committee on Physician/Hospital Issues
- Co-author, TMA Policy Statement on Physician Ownership

DISCLOSURE OF AFFILIATIONS

- Cardiovascular Provider Resources, Inc.
- HeartPlace, PA
- Texas Chapter American College of Cardiology
- Southwestern Medical Foundation
- TEXPAC
- MDPAC
- ACCPAC
- HeartPlace PAC

Board of Trustees

(Vote for three)

Joseph S. Valenti, MD

The Lone Star Caucus is very pleased to nominate Joseph S. Valenti, MD, FACOG, for the position of at-large member of the TMA Board of Trustees.

A gynecologist in private practice in Denton for the past 20 years, Dr. Valenti is a fellow of the American College of Obstetricians and Gynecologists. He graduated with honors from the State University of New York at Buffalo medical school and completed residency at Women & Children's Hospital of Buffalo.

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

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

Dr. Valenti has extensive organizational and leadership experience, serving his peers at almost every level of the Texas Medical Association. Both at the state and national levels, he has been a consistent stalwart for physician-owned, physician-driven, physician-led health care.

Personal Statement: *"The history of the Texas Medical Association from 1853 to today is one replete with a common thread: Physicians joining together to accomplish a vision, "To Improve the Health of All Texans." TMA's 2020 strategic plan outlines the path forward, and certainly our original 35 founders could hardly have imagined how complex this task would become: tort reform, balanced billing, political action, value-based care, and evidence-based regulation, to name a few of the factors. Nonetheless, we are faced with a future that we must walk together with our patients. We are their stewards and they are our*

partners, and we can succeed only if we are kept always vigilant of that fact. Required of us is leadership, dedication, honesty, a working understanding of the determinants of health care costs, and an unwavering belief that we can never give up the ability to do what is in the aligned physician and patient best interest. I humbly ask for your support so that I may continue to carry the fight forward on behalf of our TMA, our patients, and all Texans."

PROFILE:
Name: Joseph S. Valenti, MD
Specialty: OBGYN
Medical School: State University of New York at Buffalo, 1994
Residency Program: Women & Children's Hospital of Buffalo 1998
Board Certifications(s): American Board of Obstetrics and Gynecology
Primary Residence (City, State): Dallas, TX
What is your current practice status? Check all that apply and provide percentages:

Direct Patient Care: solo, small group, or shared overhead	100%

Primary Employer and Employment Location (city, state): Co-Owner, Caring for Women, PA, Denton, 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: The Physicians Foundation, Medical Directorship – Medical City Frisco
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
Current
- District chair, TEXPAC
- Delegate, TMA House of Delegates

Past
- Member, Task Force on Balanced Billing
- Chair and member, Council on Socioeconomics
- Chair and member, Council on Constitution and Bylaws
- Chair and member, Committee on Maternal and Perinatal Health
- District vice chair, TEXPAC
- Chair and delegate to the AMA House of Delegates Young Physician Section
- Member, Task Force on Physician Services Organization
- Member, Ad Hoc Committee on TMA of the Future
- Member, Task Force on Accountable Care Organizations
- Alternate delegate, TMA House of Delegates

DISCLOSURE OF AFFILIATIONS:
- Physicians Foundation Board of Directors
- Caring for Women, PA
- TMLT Business Development Group
- TEXPAC contributor
- Lone Star Alliance Board of Directors

Board of Trustees YPS Member

(Vote for one)

Lindsay Botsford, MD

The Harris County Medical Society (HCMS) is honored to endorse the candidacy of Lindsay Botsford, MD, MBA, for election to the Young Physician Section seat on the TMA Board of Trustees.

Dr. Botsford has been an active member of TMA and HCMS since 2003, when she was in medical school at Baylor College of Medicine. As a medical student, Dr. Botsford was a leader on the TMA Medical Student Section Executive Committee and served on the TMA Board of Trustees in 2006. She completed her family medicine residency at Baylor College of Medicine/Kelsey-Seybold Clinic. During her first eight years in practice in both employed and academic settings, she has served within HCMS on the Membership Committee and as the chair of the Employed Physicians Committee. In 2014, she was elected as an officer of her county branch society, of which she served as president in 2016. That position allowed her to sit on the Harris County Medical Society Executive Board for 2016.

Dr. Botsford believes that leadership skills are critical for physicians. She completed her MBA at the University of Houston's Bauer College of Business in 2011 while working as a practicing family physician. In 2013, she graduated from the TMA Leadership College.

In 2014, Dr. Botsford was appointed to the TMA Committee on Medical Home and Primary Care, and in 2016, was appointed chair of that committee. In 2017, she became chair of the TMA Young Physician Section. Dr. Botsford also has been active within organized medicine at the national level, including serving on the American Academy of Family Physicians Commission on Quality and Practice from 2014 to 2018 and as chair in 2018. In 2017, she was appointed to the National Quality Forum's Primary Care and Chronic Illness Standing Committee.

In a short period, Dr. Botsford has distinguished herself as an educator in family medicine. She earned the TMA bronze- and silver-level Recognition for Excellence in Academic Medicine for her work as a faculty member in the Memorial Family Medicine Residency Program. In her role as medical director at Memorial Hermann Medical Group-Physicians at Sugar Creek in Sugar Land, she is involved in projects related to quality, registries, electronic health record optimization, and population health. She received her certification in medical quality from the American Board of Medical Quality in 2017.

Dr. Botsford clearly understands the pressures on young physicians, both personal and professional. She has demonstrated the commitment to lead that we need as a representative on the TMA Board of Trustees.

Personal Statement: *"Because of my experiences in patient care, teaching, and leading, and as a mom to two small children, I understand the issues that young physicians and health care are facing. The administrative burden is growing, and burnout is rampant. We must find ways to generate workable solutions that balance protecting our profession and patients while paving a path forward for change."*

PROFILE

Name: Lindsay Botsford, MD, MBA
Specialty: Family Medicine
Medical School and Post Graduate Education (with years):
Baylor College of Medicine, 2007
University of Houston, Bauer College of Business, 2011
Residency Program: Baylor College of Medicine/Kelsey-Seybold Clinic, 2010
Board Certification(s): Family Medicine
Primary Residence (City, State): Houston, TX
What is your current practice status? Check all that apply and provide percentages:

Direct Patient Care: non-profit corporation [formerly 5.01(A) corporation]	30%
Academic	50%
Other; please describe: Medical Director, Physicians at Sugar Creek	20%

Primary Employer and Employment Location (city, state): Memorial Hermann Medical Group-Physicians at Sugar Creek, Sugar Land, TX
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas. No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses.
American Academy of Family Physicians
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
Current

- Young Physicians Section Chair
- Committee on Medical Home and Primary Care, Chair
- House of Delegates, Delegate
- TEXPAC

Past

- Young Physician Section AMA Delegate and Chair Elect
- House of Delegates Alternate Delegate
- TEXPAC District Chair and District Vice Chair
- Leadership College Graduate
- Council on Socioeconomics, Resident and Fellow Section Representative
- Resident and Fellow Section Member
- Board of Trustees, Medical Student Section Representative
- Board of Councilors, Medical Student Section Representative
- Council on Health Service Organizations, Medical Student Section Alternate Representative
- Medical Student Section AMA Delegate

DISCLOSURE OF AFFILIATIONS

American Medical Association YPS Strategy and Leadership Committee, Member
Harris County Medical Society Employed Physicians Committee, Chair
Harris County Medical Society Membership Committee, Member,
Texas Academy of Family Physicians

- Nominating Committee, Member
- Finance Committee Member
- Bylaws Committee Member
- Leadership Development Member

American Academy of Family Physicians Commission on Quality and Practice, Chair
Memorial Hermann Medical Group/PhyTex Board, Member
Harris County Academy of Family Physicians, President
Memorial Family Medicine Residence Program, Faculty

AMA Alternate Delegate

(Vote for one)

Laura Faye Gephart, MD

Laura Faye Gephart, MD, MBA, FACOG, from The University of Texas Rio Grande Valley is seeking election as an alternate delegate on the TMA Delegation to the American Medical Association.

Dr. Gephart's passion for the patients, policy, politics, and business of medicine inspired her to engage in organized medicine and to pursue a master's in business administration with a focus on health care administration.

Dr. Gephart has been active in organized medicine including AMA since 2005. She first served in the AMA House of Delegates in 2008. Since moving to Texas for a fellowship in female pelvic medicine and reconstructive surgery, Dr. Gephart has been an active participant in TMA, serving first on the TEXPAC Executive Board and then on the TMA Board of Trustees as the Resident and Fellow Section representative. She also served as an AMA delegate through the AMA Resident and Fellow Section, allocating her membership so that Texas received another full voting seat in the AMA House of Delegates.

As a fellow of the American Congress of Obstetricians and Gynecologists, Dr. Gephart has cared for Texas women as a primary care physician and a surgical subspecialist. As an educator in a newly established public medical school and residency program, Dr. Gephart can speak to the realities of starting and sustaining training programs for the future physicians of Texas. The unique geography and demographics of the Rio Grande Valley enable Dr. Gephart to provide perspective to the delegation from underrepresented patients and doctors.

Dr. Gephart's energy and expertise allowed her to be elected twice to the AMA Council on Medical Service as the Resident and Fellow Section representative. Before dedicating herself to the AMA Council on Medical Service, Dr. Gephart was elected twice to the national Governing Council of the AMA Medical Student Section. Through her training as a medical student in California and obstetrician-gynecology residency in Florida, Dr. Gephart has established relationships with other large delegations in AMA.

Dr. Gephart understands the needs of Texas physicians, trainees, students, and patients. She knows 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. Dr. Gephart's addition to the TMA Delegation to the AMA as an alternate delegate would be an asset to the delegation.

Personal Statement: *"I would be honored to serve the Texas Medical Association, Texas doctors, and our patients as part of our Delegation to the AMA. Our job on the delegation is to make AMA more like TMA. Through my knowledge of and experience in the AMA House of Delegates, 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

Name: Laura Faye Gephart MD
Specialty: Female Pelvic Medicine and Reconstructive Surgery
Medical School and Post Graduate Education (with years): Loma Linda University, MD MBA (2010)
Internship, residency and fellowship Programs:

- Internship - Howard University Hospital
- Residency - University of South Florida
- Fellowship - Scott & White Healthcare

Board Certification(s): American Board of Obstetrics and Gynecology
Primary Residence (City, State): Edinburg, Texas
What is your current practice status? Check all that apply and provide percentages:

Academic	100%

Primary Employer and Employment Location (city, state): University of Texas, Rio Grande Valley
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas. No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses. Doctors Hospital At Renaissance
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?

<u>Current</u>

- TMA Leadership College Scholar
- Committee on Medical Home and Primary Care, Member
- TMA House of Delegates, Delegate
- Young Physician Section, Member
- LGBTQ Health Workgroup, Member

<u>Past</u>

- Texas Delegation to the AMA, Resident and Fellow Section Delegate
- AMA Resident and Fellow Section House of Delegates, TMA Representative
- TMA Board of Trustees, Resident Member
- Resident and Fellow Section, Member
- TEXPAC Board of Directors, TMA Resident and Fellow Section Member

AMA Alternate Delegate

(Vote for one)

Alexander B. Kenton, MD

The Bexar County Medical Society (BCMS) and the Bexar Delegation to TMA announce the candidacy of Alexander B. Kenton, MD, for alternate delegate to the TMA Delegation to the American Medical Association.

Dr. Kenton has been a member of BCMS and TMA since he moved back to Texas after residency. An Alpha Omega Alpha honor medical society graduate of The University of Texas Medical Branch at Galveston, Dr. Kenton completed his residency program in internal medicine/pediatrics at the Medical Center of Delaware, followed by a fellowship in neonatology at Baylor College of Medicine. He is board certified in pediatrics and neonatology.

Dr. Kenton is actively involved in organized medicine. He has served on the TMA Ad Hoc Committee on Medicaid, CHIP, and the Uninsured as well as the TMA Council on Science and Public Health. In addition, Dr. Kenton previously served as TEXPAC membership chair and presently is chair of the TEXPAC Candidate Evaluation Committee.

A current member of the Texas Pediatric Society Committee on Fetus and Newborn, Dr. Kenton is a past chair of the Special Task Force on Breastfeeding, where he spearheaded a successful four-year effort to have the state of Texas pay for donor breast milk use in hospitals to promote the prevention of necrotizing enterocolitis.

Locally, Dr. Kenton serves on the Bexar Delegation to TMA and is chair of the BCMS Legislative and Socioeconomics Committee. Additionally, Dr. Kenton has served as chief of pediatric medicine and chief of staff for the Methodist Children's Hospital in San Antonio.

Dr. Kenton is up to date on the latest issues concerning Texas physicians today and is engaged in the day-to-day political challenges facing the House of Medicine. Dr. Kenton would represent TMA and the House of Medicine well in AMA.

Personal Statement: "*If elected, I assure you, my fellow physicians, wholeheartedly that I will continue the great work our TMA delegates to AMA have perpetuated, ensuring the House of Medicine is placed*

back in the leadership position so that physicians are the ones who determine our future and the future of our patients. When the Affordable Care Act (ACA) was originally being debated, I heard it said that the Obama administration was not even open to alternatives, that the outcome was a prenegotiated one. As it turned out, the ACA became just the latest salvo in a long battle to reduce physicians from leading the crusade for health to being managed by payers, hospitals, and the government. Ever since that fateful year, I have been completely engaged in advocacy and organized medicine. For the past six years, aligned with the Texas Medical Association, I have relentlessly fought to ensure physicians always have the lead voice for health care policy. Now, more than ever, is the opportunity to help energize AMA to meet this challenge forcefully and aggressively."

PROFILE

Name: Alexander B. Kenton, MD
Specialty: Neonatal/Perinatal Medicine
Medical School and Post Graduate Education (with years): University of Texas Medical Branch-Galveston, 1993-1997
Residency Program: Christiana Care Internal Medicine/Pediatrics
Board Certification(s): Pediatrics and Neonatal/Perinatal Medicine
Primary Residence (City, State): San Antonio. Texas
What is your current practice status? Check all that apply and provide percentages:

Direct Patient Care: large group practice (over 20 members)	100%

Primary Employer and Employment Location (city, state): Mednax San Antonio, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses. Methodist Children's Hospital Chief of Staff
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?

<u>Current</u>

- TMA House of Delegates, Delegate
- TEXPAC Candidate Evaluation Committee, Chair
- TEXPAC Executive Committee, Member

<u>Past</u>

- Ad Hoc Committee on Medicaid, CHIP and the Uninsured, Member
- TEXPAC Membership Committee, Chair
- Council on Science and Public Health, Member
- TEXPAC, District Vice Chair
- TMA House of Delegates, Alternate Delegate

2017 AUDIT TRAIL

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

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

FROM REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS:

Speakers Report 1 – TMA Election Process: That the Texas Medical Association make changes to the TMA Election Process to be consistent with TMA Bylaws. **Adopted.**

REFERRED TO: Add to TMA Policy Compendium; Speakers' Advisory Committee

STATUS: Policy 295.013 Election Process updated in the compendium. Changes to the Election Process have been communicated to the leadership of each caucus.

Board of Trustees Report 12 – Continuation of International Medical Graduate Section: 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. **Adopted.**

REFERRED TO: International Medical Graduate Section

STATUS: Deferred until IMG Section report is submitted in 2019

Speaker and Council on Constitution and Bylaws Joint Report 1 – Parliamentary Authority Transition for TMA: That: (1) the American Institute of Parliamentarians Standard Code of Parliamentary Procedure be adopted as TMA's parliamentary authority, effective at the conclusion of the 2017 Annual Session; (2) TMA Bylaws Chapter 3, House of Delegates, Section 3.70, Business and Subsection 3.73, Rules of conduct, be amended; (3) TMA Bylaws Chapter 12, County Societies, Section 12.40, Structure, Subsection 12.411, Duties, be amended; (4) TMA Bylaws Chapter 14, Rules of Order, be amended; and (5) standing rules for TMA House of Delegates' parliamentary procedure, in addition to the American Institute of Parliamentarians Standard Code of Parliamentary Procedure, be adopted. **Adopted.**

REFERRED TO: Council on Constitution and Bylaws; Speakers' Advisory Committee

STATUS: TMA Bylaws and House of Delegates procedures have been updated accordingly.

Resolution 101 – Election of TMA Board of Trustees Members (Lone Star Caucus): That: (1) 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; (2) TMA Bylaws, Chapter 4, Board of Trustees, Section 4.40, Term, tenure, and vacancies of at-large positions, be amended; and (3) TMA Bylaws, Chapter 7, Elections, Section 7.42, Balloting, Subsections 7.421, First Ballot, and 7.422, Run-off ballot, be amended. **Referred to the Speakers' Advisory Committee and Council on Constitution and Bylaws with a report back at A-18.**

REFERRED TO: Speakers' Advisory Committee; Council on Constitution and Bylaws

STATUS: See SPKR Report 2-A-18 and CCB Report 2-A-18 in this handbook.

Resolution 103 – Texas Medical Board License Renewal Notifications and Payment (Harris County Medical Society): That: (1) 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 (2) TMA request that TMB (a) provide an electronic or email-based means to communicate routine license renewal information to licensed physicians, in addition to U.S. Postal Service mail; (b) institute an electronic license renewal notification and an option for electronic auto-renewal payment; and (c) provide for acceptance of credit card or bank electronic payment systems to convey payments for license renewals and fees. **Adopted.**

REFERRED TO: Add to TMA Policy Compendium; Communications Division; Membership Operations & Business Intelligence

STATUS: New policy 175.022 Texas Medical Board License Renewal Notifications and Payment added to compendium. Texas medical licenses are good for two years and generally expire on a rolling basis at one of four times during the year: Feb. 28, May 31, Aug. 31, or Nov. 30. Even-numbered licenses expire in even-numbered years, and odd-numbered licenses expire in odd number years. License expiration dates are stored in TMA's membership database. As a service to members, TMA has begun providing automated, e-mail reminders beginning with the licenses that expire May 31, 2018. Those reminders go out 30 days, and again seven days, before the member's license expires. The reminders include: the license expiration date; the steps of the renewal process, with links to the Texas Medical Board's online registration page; continuing medical education requirements for license renewal and links to free CME from the TMA Education Center; and contact information for the TMA Knowledge Center to answer any questions.

Resolution 105 – TMA Outreach to Displaced and Refugee Physicians (Harris County Medical Society): That: (1) 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 (2) 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. **Adopted.**

REFERRED TO: International Medical Graduate Section

STATUS: See IMGS Report 1-A-18 in the Informational Reports section of this handbook.

Resolution 106 – Reduced and Alternative Documentation and Administrative Requirements for Medical Documentation for Prescribers in Times of Declared Disasters (Harris County Medical Society): That: (1) 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; (2) TMA urge TMB to adopt these reduced and alternative documentation and administrative requirements during times of declared disasters; and (3) any waiver in requirements exist only in a time of declared disaster and not during normal business operations. **Adopted.**

REFERRED TO: Office of the General Counsel

STATUS: A letter has been forwarded to the Texas Medical Board (TMB) Acting Executive Director with a request that it be considered by the TMB and appropriate regulations and policies

adjusted accordingly. If the TMB fails to act, the matter will be forwarded to the Council on Legislation to consider statutory changes in 2019.

Resolution 107 – Support of Evidence-Based Medicine (Young Physician Section, Resident and Fellow Section, and Medical Student Section): That: (1) TMA adopt policy opposing the criminalization of evidence-based medical care; (2) TMA policy also oppose the revocation of a medical license for the provision of evidence-based medical care; and (3) TMA encourage TEXPAC to consider previous and planned actions to criminalize the practice of medicine when deciding endorsements and allocation of funds. **Referred.**

REFERRED TO: Board of Councilors

STATUS: See BOC Report 4-A-18 in this handbook.

Resolution 109 – Transparency in Election in the House of Delegates (Angelina County Medical Society): That: (1) 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 (2) 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.. **Referred to the Speakers' Advisory Committee with a report back at A-18.**

REFERRED TO: Speakers' Advisory Committee

STATUS: See SPKR Report 1-A-18 in this handbook.

Resolution 111 – Addressing Physician Mental Health Status Disclosures (Medical Student Section): That: (1) 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; (2) 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 (3) 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. **Referred.**

REFERRED TO: Council on Medical Education

STATUS: See CME Report 1-A-18 in the Informational Reports section of this handbook.

Resolution 113 – HIPAA and Physician Rating Websites (Harris County Medical Society): That: (1) 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 (2) 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. **Adopted.**

REFERRED TO: Council on Legislation; Add to TMA Policy Compendium

STATUS: New policy 165.010 HIPAA and Physician Rating Websites added to compendium. This policy will inform TMA's advocacy activities related to this topic going forward.

FROM REFERENCE COMMITTEE ON MEDICAL EDUCATION:

Council on Medical Education Report 3 – Support for Exceptions to Medicare GME Cap-Setting Deadlines in Underserved Areas: That: (1) TMA adopt policy on Exceptions to Deadlines for Setting Medicare GME Funding Caps; and (2) the Texas Delegation to the AMA take CME Report 3-A-17 to the AMA House of Delegates for consideration as new AMA policy. **Adopted.**

REFERRED TO: Add to TMA Policy Compendium; Texas Delegation to the AMA

STATUS: New policy 205.037 Exceptions to Deadlines for Setting Medicare GME Funding Caps added to compendium. AMA adopted Resolution 323-A-17 asking that our American Medical Association advocate to the Centers for Medicare & Medicaid Services for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-setting deadline for new residency programs in underserved areas and/or economically depressed areas. The Council on Medical Education notified Texas medical school deans at the 2017 TMA Fall Conference of the adoption of these new TMA and AMA policies.

Council on Medical Education Report 4 – Rural Training Tracks: That TMA adopt policy on Support of Rural Residency Training and State Grant Program for Promoting Rural Training Tracks. **Adopted.**

REFERRED TO: Add to TMA Policy Compendium

STATUS: New policy 185.023 Support of Rural Residency Training and State Grant Program for Promoting Rural Training Tracks added to compendium. The Council on Medical Education notified the Texas medical school deans about the new policy at the 2017 TMA Fall Conference.

Council on Medical Education Report 5 – Need for Continued Expansion of GME Capacity: That TMA adopt policy on Building the Future Physician Workforce. **Adopted.**

REFERRED TO: Add to TMA Policy Compendium

STATUS: New policy 185.024 Building the Future Physician Workforce added to compendium. This policy will be available to help guide advocacy activities on GME expansions during the 2019 Texas Legislative Session.

Council on Medical Education Report 6 – Referral of Res. 201-A-16, Recognition of Alternative Recertification Boards (Harris County Medical Society), and Res. 207-A-16, Recognition of National Board of Physicians and Surgeons and National Board of Osteopathic Physicians and Surgeons (Ori Hampel, MD): That TMA: (1) approve policy on Initial Guiding Principles on Maintenance of Certification; (2) adopt policy on Monitoring Maintenance of Certification Reforms; (3) retain policy 175.006, Physician Licensure by Individual State Medical Boards; and (4) retain as amended policy 175.018, Maintenance of Certification. **Adopted.**

REFERRED TO: Add to TMA Policy Compendium

STATUS: New policy 175.024 Monitoring Maintenance of Certification Reforms added to compendium. TMA's Initial Guiding Principles on MOC were provided to the leadership of the American Board of Medical Specialties and the AMA Council on Medical Education.

Committee on Physician Distribution and Health Care Access Report 1 – Long-Range State Health Care Workforce Study: That TMA adopt policy in support of a long-range state health care workforce study. **Adopted.**

REFERRED TO: Council on Legislation; Committee on Physician Distribution and Health Care Access; Add to TMA Policy Compendium

STATUS: New policy 185.025 Long-Range State Health Care Workforce Study added to compendium. The new policy was made available to the Texas Higher Education Coordinating Board which administers the State Physician Education Loan Repayment Program. TMA's policy on this also will form the basis for advocacy activities during the 2018 interim and 2019 legislative session related to physician education loan repayment.

Committee on Physician Distribution and Health Care Access Report 2 – Enhancements to State Physician Education Loan Repayment Program: That: (1) TMA adopt policy on Enhancing the State's Physician Education Loan Repayment Program; (2) TMA policies 205.021, State Loan Repayment Program, 205.002, Support for Student Loan Funds Repayment, and 185.017, Addressing the Threat to Primary Care in Texas, be retained as amended; and (3) TMA policies 205.034, Reinstate and Enhance Texas Physician Education Loan Repayment Program, and 205.023, Physician Education Loan Repayment Program, be deleted. **Adopted.**

REFERRED TO: Committee on Physician Distribution and Health Care Access; Add to TMA Policy Compendium

STATUS: New policy 205.038 Enhancing the State's Physician Education Loan Repayment Program added to compendium. Policies 205.021 State Loan Repayment Program, 205.002 Support for Student Loan Funds Repayment, and 185.017 Addressing the Threat to Primary Care in Texas amended in the compendium. The new and revised policies have been made available to the Texas Higher Education Coordinating Board who administers the State Physician Education Loan Repayment Program. They also will form the basis for advocacy activities during the 2018 interim and 2019 legislative sessions related to physician education loan repayment.

Resolution 201 – Inclusion of Advocacy Education in Medical School Curricula (Harris County Medical Society): That: (1) 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 (2) 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. **Referred.**

REFERRED TO: Council on Medical Education

STATUS: The Council on Medical Education sent a letter on Feb. 20 to each Texas medical school dean to inform them of the medical students' interest in advocacy education. Medical schools already offering advocacy education were commended by the council and those who are not, were encouraged to do so. A copy of the letter was provided to Harris County Medical Society, as well as to the primary author of the resolution.

Resolution 202 – Medical School Clinical Skills Exams (Medical Student Section): 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 Medical 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. **Referred.**

REFERRED TO: Council on Medical Education

STATUS: The Council on Medical Education sent a letter on Feb. 9, 2018, to the National Board of Medical Examiners and National Board of Osteopathic Medical Examiners conveying concerns expressed by Texas medical students about the expense and burden of the USMLE Step 2-CS and COMLEX-USA Level 2-PE exams. The boards were encouraged to give thoughtful and thorough consideration of all available options for reducing the cost and hardships of the exam on medical students and to engage with the students in discussion on these topics. A copy of this letter was provided to the Medical Student Section Governing Council.

FROM REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH:

Council on Science and Public Health Report 1 – All Hazards Disaster Planning: That: (1) TMA adopt Disaster Preparedness Planning and Response policy; (2) policies 260.076, All Hazards Disaster Planning, and 260.067, Disaster Preparedness be deleted; and (3) 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. **Adopted.**

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

STATUS: New policy 260.103 Disaster Preparedness Planning and Response added to compendium. See Audit Trail status on Resolution 301-A-17 for more information.

Council on Science and Public Health Report 2 – Parental Leave: That: (1) 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; and (2) 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. **Adopted.**

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

STATUS: New policy 260.104 Parental Leave added to compendium. This was discussed with leadership at Texas Department of State Health Services in 2017 and staff will continue to follow up on opportunities for promoting communications on this matter. There was an article on parental leave in the October 2017 publication of *Texas Medicine*.

Committee on Child and Adolescent Health and Task Force on Behavioral Health Joint Report 4 – Resolution 311-A-16, Sexual Orientation Change Efforts in Minors: That: (1) TMA adopt the recommended policy on sexual orientation change efforts in minors; and (2) amend Policy 55.004, Adolescent Sexual Activity. **Adopted.**

REFERRED TO: Add to TMA Policy Compendium

STATUS: New policy 55.058 Sexual Orientation Change Efforts in Minors added to compendium.

Committee on Infectious Diseases and Committee on Child and Adolescent Health Joint Report 5 – Preexposure Prophylaxis as HIV Prevention: That TMA promote awareness among physicians of pre-exposure prophylaxis as a tool for HIV infection prevention. **Adopted.**

REFERRED TO: Committee on Infectious Diseases; Add to TMA Policy Compendium

STATUS: New policy 15.014 Preexposure Prophylaxis as HIV Prevention added to compendium. The Committee on Infectious Diseases and the Committee on Child and Adolescent Health continue to support a workgroup to promote increased awareness of preexposure prophylaxis.

Board of Councilors Report 3 - Resolution 307-A-16, Gender and Sex Options on Medical Paperwork: That the Council on Science and Public Health provide recommendations to guide TMA activities related to gender and sexual diversity. **Adopted as amended by substitution.**

REFERRED TO: Council on Science and Public Health

STATUS: See CSPH Report 8-A-18 in this handbook.

Resolution 301 – Creating a Statewide Crisis Standards-of-Care Framework (Dallas County Medical Society): That the Texas Medical Association (1) 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; (2) support legislative efforts that promote physician-led decision-making during public health emergencies, using nationally recognized guidelines; and (3) help identify any legal barriers that would prohibit the implementation of a crisis standards-of-care framework during a declared public health emergency. **Adopted.**

REFERRED TO: Council on Science and Public Health; Council on Legislation; Office of the General Counsel; Add to TMA Policy Compendium

STATUS: New policy 260.105 Statewide Crisis Standards-of-Care added to compendium. A meeting was convened with staff from Texas Department of State Health Services (DSHS), and calls were organized between DSHS and TMA members with assistance from the chair of TMA's Council on Science and Public Health. There has not been agreement from DSHS to provide support for this activity. Further work will proceed with a focus on supporting local efforts.

Resolution 302 – Palliative Care (Larry Driver, MD): That: (1) 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 (2) 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. **Adopted.**

REFERRED TO: Committee on Cancer

STATUS: A letter of support and recognition was sent to members of the state's Palliative Care Interdisciplinary Advisory Council. A commentary on palliative care was submitted by the Committee on Cancer for inclusion in the November 2017 issue of *Texas Medicine*. The committee also will have a CME program on palliative care as part of the cancer track at TexMed 2018. The committee will continue to support this activity.

Resolution 303 – Sudden Increase in Liability Claims for Wernicke's Encephalopathy in Bariatric Surgery Patients (Harris County Medical Society): That the appropriate Texas Medical Association council or committee review existing evidence regarding the prevalence and presentation of Wernicke's encephalopathy and other nutritional deficiencies and sequelae after bariatric procedures, and if appropriate, provide information to all Texas physicians. **Adopted as amended.**

REFERRED TO: Council on Science and Public Health

STATUS: The Council on Science and Public Health considered the topic at fall and winter meetings and a presentation on the topic will be provided to the council at their TexMed 2018 meeting.

Resolution 304 – Rejection of Discrimination (Young Physician Section, Resident and Fellow Section, and Medical Student Section): That: (1) 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; (2) 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' (a) self-education regarding care for the LGBTQ population, (b) provision of support to families in developing healthy relationships with their youth regardless of sexual orientation, and (c) discussion of consequences and health risks of varying levels of acceptance and rejection of LGBTQ youth; (3) 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 (4) the Council on Science and Public Health provide recommendations to guide TMA activities related to gender and sexual diversity. **Adopted as amended.**

REFERRED TO: Council on Science and Public Health

STATUS: See CSPH Report 1-A-18 in this handbook.

Resolution 305 – Addressing the Diaper Gap (Medical Student Section): That: (1) the Texas Medical Association advocate for elimination or reduction of taxes imposed on infant and adult diapers; and (2) the Texas Delegation forward this resolution immediately to the American Medical Association House of Delegates. **Referred.**

REFERRED TO: Council on Science and Public Health; Council on Legislation; Office of the General Counsel

STATUS: See CSPH Report 2-A-18 in this handbook.

Resolution 306 – Addressing the Need for Improved Water Supply Quality in Texas (Medical Student Section): That: (1) The Texas Medical Association advocate for regulatory action to support public health or infrastructural measures to lower toxic and carcinogenic chemicals, and ensure safe and clean community water systems; and (2) TMA promote awareness among physicians regarding safe drinking water. **Adopted as amended.**

REFERRED TO: Council on Legislation; Communications Division; Add to TMA Policy Compendium

STATUS: New policy 260.106 Improving Water Supply Quality in Texas added to compendium. This policy will inform TMA's advocacy activities related to this topic going forward. Since the 2017 meeting of the House of Delegates, TMA publications have reported on drinking water safety several times:

Texas Medicine Today:
- A story about Texas' oral health mentioned the drop in fluoridated drinking water.
- A story about a Legionella Bacteria breakout mentioned unsafe drinking water.

Texas Medicine:
- A December 2017 story about disposing medications warns of the dangers of medications flushed down a toilet seeping into the water supply.

- A November 2017 story on the long-term health problems expected from Hurricane Harvey discussed the health risks associated with flood waters.

This coverage will continue. A recent report highlighted polluted drinking water (contaminated with radium, arsenic, lead, and copper) in 37 rural Texas water utilities. Based on that report, staff will write a story on the cause, how the situation can be improved, and what it means for rural physicians, who are already in short supply and overworked.

Resolution 307 – Reducing Errors in Pharmacy (Lubbock-Crosby-Garza County Medical Society): That TMA study the causes of errors in e-prescribing in pharmacies and suggest ways to reduce these errors. **Referred.**

REFERRED TO: Ad Hoc Committee on Health Information Technology

STATUS: See CPMS Report 1-A-18 in this handbook.

Resolution 308 – Expansion of Next Generation 911 (Medical Student Section): Adoption of amended TMA Policy 100.008, Statewide Emergency Communication Network System: Texas should maintain a robust and adequately funded statewide 911 communications system and, as part of that effort, county medical societies should assist in advocating needed resources to support their local 911 emergency systems and local expansion of the emergency service infrastructure to include next generation 9-1-1 features. **Adopted as amended by substitution.**

REFERRED TO: Add to TMA Policy Compendium

STATUS: Policy 100.008 amended in compendium.

Resolution 310 – Healthy Food in Hospitals (Medical Student Section): That: (1) the Texas Medical Association encourage hospitals to offer and promote healthy, reasonably priced, and easily accessible food options; and (2) 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. **Adopted.**

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

STATUS: New policy 130.025 Healthy Food in Hospitals added to compendium. Initial contact was made with staff of the Texas Hospital Association on this topic. They reported that there is interest in working on this with TMA and focusing on some of the hospitals that have already adopted policy in this area.

Resolution 312 – Implementing a Sugar-Sweetened Beverage Tax in Texas (Medical Student Section): That the Texas Medical Association support the incorporation of a Texas-wide sugar sweetened beverage tax. **Referred.**

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

STATUS: See CSPH Report 4-A-18 in this handbook.

Resolution 313 – Improved Concussion Protocol to Reduce Psychological Morbidity in High School Athletes (Medical Student Section): That: (1) 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; (2) TMA support legislation that recommends that athletes who have had a concussion receive information about psychiatric support; (3) TMA support legislation that recommends psychiatric or neuropsychiatric consultation for high school

athletes who have had a concussion; (4) TMA support legislation increasing awareness protocol for concussions across all sports; and (5) the Texas Delegation forward this resolution to the American Medical Association for consideration at the House of Delegates. **Referred to the Committee on Child and Adolescent Health.**

REFERRED TO: Committee on Child and Adolescent Health

STATUS: See CM-CAH Report 2-A-18 in this handbook.

Resolution 314 – Promoting Increased Awareness and Research for Grade School Soccer-Related Head Injury (Medical Student Section): That: (1) TMA support measures to increase public education regarding the signs, symptoms, and effects of concussive and subconcussive head injuries among student soccer athletes; and (2) 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. **Referred to the Committee on Child and Adolescent Health.**

REFERRED TO: Committee on Child and Adolescent Health

STATUS: See CM-CAH Report 2-A-18 in this handbook.

Resolution 315 – Addressing the Expanding Habitats of Vectors of Infectious Disease (Medical Student Section): That: (1) 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 (2) 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. **Adopted.**

REFERRED TO: Committee on Infectious Diseases; Communications Division; Add to TMA Policy Compendium

STATUS: New policy 260.107 Vectors of Infectious Disease added to compendium. This has been discussed by the Committee on Infectious Diseases and an article addressing some factors will be published in *Texas Medicine* in the summer of 2018. TMA also has communicated with infectious disease staff at Texas Department of State Health Services on the topic.

Resolution 316 – Addressing Transgender Public Facility Use (Medical Student Section): That the Council on Science and Public Health provide recommendations to guide TMA activities related to gender and sexual diversity. **Adopted as amended by substitution.**

REFERRED TO: Council on Science and Public Health

STATUS: See CSPH Report 1-A-18 in this handbook.

Resolution 318 – Access to Special Education Services (Medical Student Section): That: (1) 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 (2) TMA advocate for eliminating barriers to identification of and intervention in children who need special education services. **Adopted and referred to CM-CAH and the Task Force on Behavioral Health.**

REFERRED TO: Committee on Child and Adolescent Health; Task Force on Behavioral Health; Add to TMA Policy Compendium

STATUS: New policy 55.059 Access to Special Education Services added to compendium. The Committee on Child and Adolescent Health has tracked state developments in this area and will send a letter to the Texas Education Agency Commissioner to request an update for TMA.

Resolution 319 – Identification and Prevention of Adolescent Substance Abuse (Webb-Zapata-Jim Hogg County Medical Society): That: (1) 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 (2) 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. **Referred to the Task Force on Behavioral Health.**

REFERRED TO: Task Force on Behavioral Health

STATUS: The Council on Science and Public Health's Task Force on Behavioral Health has established a workgroup on substance use disorders and prioritized this topic for their work. They propose creating a plan to develop physician education and updates on how physicians can help stop teen drug and alcohol abuse. They also are tracking legislative interim hearings for opportunities to share their recommendations.

Resolution 320 – Vitamin D3 Supplementation (Webb-Zapata-Jim Hogg County Medical Society): That: (1) 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 (2) 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. **Referred.**

REFERRED TO: Council on Science and Public Health

STATUS: See CSPH Report 3-A-18 in this handbook.

Resolution 321 – Promoting Safe and Effective Disposal of Unused Medications (Webb-Zapata-Jim Hogg County Medical Society): That: (1) 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; (2) TMA assist local county medical societies with identifying, developing, and promoting safe drop off and drug disposal services; (3) TMA develop a model bill that requires written disposal information be provided at the point of purchase or delivery of a prescription; and (4) TMA convene a conference to include pharmaceutical companies and trade association representatives to evaluate programs and mechanisms for safe disposal and funding of these services. **Adopted as amended.**

REFERRED TO: Council on Science and Public Health; Office of the General Counsel; Council on Legislation; Add to TMA Policy Compendium

STATUS: New policy 95.042 Promoting Safe and Effective Disposal of Unused Medications added to compendium. This policy will inform TMA's advocacy activities related to this topic going forward. An article on the topic was published in *Texas Medicine* and staff have remained in contact with the author of the resolution to assist with materials for local presentations. A one-pager on safe disposal also was produced on this topic to support TMA testimony on substance use disorders and TMA will promote national 'take back' day scheduled for April 28, 2018.

FROM REFERENCE COMMITTEE ON SOCIOECONOMICS:

Council on Socioeconomics Report 2 - Increasing Use of Narrow Networks by Medicare Advantage Plans: That TMA adopt policy on Extending Open Enrollment for Medicare Advantage Plans, as follows: 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. **Adopted.**

REFERRED TO: Add to TMA Policy Compendium

STATUS: New policy 195.036 Extending Open Enrollment for Medicare Advantage Plans added to compendium.

Council on Socioeconomics Report 3 - Prescription Drug Price Negotiation: That TMA adopt policy on Prescription Drug Negotiation in the Medicare Program, as follows: The Texas Medical Association supports congressional authorization of Medicare to negotiate the prices of Medicare Part D plans, as it does for other goods and services. **Adopted.**

REFERRED TO: Add to TMA Policy Compendium

STATUS: New policy 195.037 Prescription Drug Negotiation in the Medicare Program added to compendium.

Council on Socioeconomics Report 4 – Prescription Drug Value Based Contracting: Adoption of new TMA policy on 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 direct care 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. **Adopted as amended.**

REFERRED TO: Add to TMA Policy Compendium

STATUS: New policy 95.043 Prescription Drug Value Based Contracting added to compendium.

Council on Socioeconomics and Select Committee on Medicaid, CHIP, and the Uninsured Joint Report 6 - Federal Medicaid Reform and Implications for Texas; and Resolution 401 - Opposition to Capped Federal Medicaid Funding (Bexar County Medical Society); and Resolution 402 - Proposed Change in Medicaid Funding (Concho Valley County Medical Society); and Resolution 407 - Medicaid Block Grants and 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); and Resolution 412 - Preference of Medicaid Funding Proposals (Harris County Medical Society): That: (1) 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; (2) 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; (3) 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; (4) 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; (5) 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; (6) TMA advocate strongly to stand against any federal or state reform measure, including block grants, that will diminish patient access to services or increase physicians' uncompensated care; and (7) 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. **Adopted as amended by addition in lieu of 401-A-17, 402-A-17, 407-A-17, and 412-A-17.**

REFERRED TO: Select Committee on Medicaid, CHIP, and the Uninsured; Council on Legislation; Add to TMA Policy Compendium

STATUS: New policy 190.036 Opposition to Federal Medicaid Block Grants for Traditional Medicaid Populations added to compendium. In 2017, TMA and the Texas Hospital Association formed a Medicaid Block Grant Task Force to coordinate state and federal advocacy relating to federal efforts to implement a Medicaid block grant or other capped funding arrangement. Opposition from physicians, hospitals, consumer organizations, and faith leaders, among others, helped to defeat federal Medicaid block grant legislation. No other bills have been filed to date. See BOT Report 7-A-18 in the Informational Reports section of this handbook for more information.

Resolution 403 - Supporting Community-Based Health Care Delivery Models for Vulnerable Patients (Dallas County Medical Society): That: (1) 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 (2) 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. **Adopted.**

REFERRED TO: Add to TMA Policy Compendium; Council on Socioeconomics

STATUS: New policy 115.020 Supporting Community-Based Health Care Delivery Models for Vulnerable Patients added to compendium. See BOT Report 7-A-18 in the Informational Reports section of this handbook.

Resolution 404 - Allowing Exceptions to the Centers for Medicare & Medicaid Services' Locum Tenens 60-Day Limit (Harris County Medical Society): That: (1) TMA 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 (2) 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. **Adopted.**

REFERRED TO: Add to TMA Policy Compendium; Texas Delegation to the AMA

STATUS: New policy 235.036 Allowing Exceptions to the Centers for Medicare & Medicaid Services' Locum Tenens 60-Day Limit added to compendium. The AMA House of Delegates adopted Resolution 717 at its 2017 Annual Meeting asking that our American Medical Association request that (1) the Centers for Medicare & Medicaid Services (CMS) create an exception process to the 60-day locum tenens limit for those physicians with unforeseen

circumstances, such as serious illness, physical impairment, or family emergency and (2) our AMA ensure that the exception process contains the same requirements as are necessary to currently bill under a CMS locum tenens arrangement.

Resolution 405 - Minimum Standards for Interstate Sale of Health Insurance Products (Harris County Medical Society): That: (1) the Texas Medical Association adopt policy on the interstate sale of health insurance products sold in Texas that supports at a minimum, the following standards, 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 (2) the Texas Delegation to the American Medical Association take to the AMA House of Delegates a resolution requesting that AMA establish minimum federal standards that do not weaken any states' requirements on network adequacy, tort and other insurance plan regulations. **Adopted as amended by addition.**

REFERRED TO: Add to TMA Policy Compendium; Texas Delegation to the AMA

STATUS: New policy 145.038 Minimum Standards for Interstate Sale of Health Insurance Products added to compendium. The Texas Delegation took Resolution 240 to the 2017 Annual Meeting of the AMA House of Delegates. The AMA house adopted Alternative Resolution 211 that, in examining proposals to sell health insurance across state lines, the AMA supports the following principles: (1) Federal or state legislation allowing the selling of health insurance across state lines, including multi-state compacts, should ensure that patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides. These protections include not weakening any state's laws or regulations involving: (a) network adequacy and transparency; (b) fair contracting and claims handling; (c) prompt pay for physicians; (d) regulation of unfair health insurance market products and activities; (e) rating and underwriting rules; (f) grievance and appeals procedures; and (g) fraud; and (2) Patients purchasing an out-of-state policy should retain the right to bring a claim in a state court in the state in which the patient resides.

Resolution 406 - Transparency and Payments for Prior Authorizations (Harris County Medical Society): That: (1) TMA Policy 235.034, Authorizations Initiated by Third-Party Payers, be amended; (2) 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; (3) prior authorizations may be allowed for only new medications and not for medications that patients have been receiving previously and continuously; (4) 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; (5) 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 (6) the Texas Delegation to the American Medical Association take this resolution to AMA for a national unified movement. **Referred**.

REFERRED TO: Council on Socioeconomics

STATUS: See CSE Report 3-A-18 in the supplement to this handbook.

Resolution 408 - Compensation of Physicians for Authorizations and Preauthorizations (Ori Z. Hampel, MD): That insurance and managed care companies ("payers") compensate physicians for the time that physicians and their staff spend on authorization and preauthorization procedures. Such compensation shall be paid in full by payers to physicians without deductible, coinsurance, or copayment billable to patients. The fee schedule shall be based on the compensation due physicians for direct patient

care according to the Current Procedural Terminology (CPT) coding system. For physicians contracted with payers, the payers shall compensate the physician at the contracted fee schedule. For out-of-network physicians, the payers shall compensate physicians at 60 percent of billed charges. The physician and/or physician staff shall track the time spent per patient per day performing tasks related to authorization and preauthorization. The physician shall bill the payer in accordance with a specified conversion table of time spent to CPT code. Billable minutes for authorization and preauthorization include, but are not limited to, time spent filling out forms, making telephone calls (including time spent negotiating phone trees and hold time), documenting in the patient's medical record, communicating with the patient, printing, copying, and faxing. Texas laws pertaining to payment timeliness shall apply to payers for such billing as well. **Referred.**

REFERRED TO: Council on Socioeconomics

STATUS: See CSE Report 4-A-18 in the supplement to this handbook

Resolution 409 - Medicaid Payments for Speech Therapy, Physical Therapy, and Occupational Therapy (Medical Student Section): That: (1) 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 (2) TMA collaborate with specialty societies to bring forth educational materials for legislators and the general public explaining the purpose of nonphysician health services, such as speech therapy, physical therapy, and occupational therapy, in promoting healthy children. **Referred to the Select Committee on Medicaid, CHIP, and the Uninsured for decision.**

REFERRED TO: Select Committee on Medicaid, CHIP, and the Uninsured

STATUS: TMA continues to advocate vigorously for increased Medicaid physician payments. In December, TMA formed a new task force with the Texas Hospital Association to advocate for new monies to increase physician payments. TMA's incoming president will chair the task force. See TMA BOT Report 7-A-18 in the Informational Reports section of this handbook for additional information.

Resolution 410 - Public-and Private-Sector Funding of Interpretation Services for Limited English Speakers and American Sign Language (Medical Student Section): That: (1) 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; (2) TMA support expanded legislation that might arise concerning reimbursement of interpretive services for both American Sign Language and limited English speakers; and (3) TMA advocate for increased access to qualified medical interpretive services for physicians. **Adopted.**

REFERRED TO: Select Committee on Medicaid, CHIP, and the Uninsured; Council on Socioeconomics; Council on Legislation; Add to TMA Policy Compendium

STATUS: New policy 235.037 Public and Private Sector Funding of Interpretation Services for Limited English Speakers and American Sign Language added to compendium. This policy will inform TMA's advocacy activities related to this topic going forward.

Resolution 411 - Clearer Language Regarding the Physician's Role in Providing Auxiliary Aid for Effective Communication Under Current Federal Laws (Medical Student Section): That: (1) 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; (2) 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; (3) 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 (4) the Texas Delegation to the American Medical Association bring this resolution to the AMA House of Delegates. **Referred.**

REFERRED TO: Council on Socioeconomics

STATUS: See CSE Report 5-A-18 in the supplement to this handbook

Resolution 413 - Addressing Zika Through Increasing Medicaid Coverage of Insect Repellent (Medical Student Section): That: (1) TMA advocate for continued Medicaid coverage of insect repellent; and (2) TMA advocate for men insured through Medicaid to receive similar insect repellent prescription coverage as their female counterpart. **Adopted.**

REFERRED TO: Select Committee on Medicaid, CHIP, and the Uninsured

STATUS: As a result of TMA advocacy, Texas Medicaid will pay for mosquito repellent for males aged 14 and older, females ages 10-55, and pregnant women of any age. For 2018, the benefit began on Feb. 12 and will run continuously year-round.

Revised

TEXAS MEDICAL ASSOCIATION
2018 HOUSE OF DELEGATES ANNUAL SESSION

OPENING SESSION
Friday, May 18, 8 am, Expo Hall, Level 2, JW Marriott San Antonio Hill Country Resort and Spa
(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
   Mark J. Kubala, MD, Past President

3. Report of Reference Committee on Credentials
   Leah H. Jacobson, MD, Chair

4. Approval of May 5-6, 2017 Minutes
   Michelle A. Berger, MD, Secretary/Treasurer

5. Address of Texas Medical Association Alliance President
   Karen Lairmore

6. Address of Texas Medical Association President
   Carlos J. Cardenas, MD

7. Board of Trustees Annual Association Finances Report
   David N. Henkes, MD, Chair

8. Section Awards
   Young Physician Section, Lindsay K. Botsford, MD, Chair
      Young at Heart
   Resident and Fellow Section, Habeeb M. Salameh, MD, Chair
      J.T. “Lamar” McNew, MD
   Medical Student Section, Jennifer E. Nordhauser, Chair
      C. Frank Webber, MD
      Student of the Year

9. American Medical Association Update
   David O. Barbe, MD, MHA, AMA President

10. Presentation by The Physicians Foundation
    Timothy B. Norbeck, CEO

11. Nominating Speeches
    President-Elect
    Trustees
    AMA Alternate Delegates

12. Recognition of TMA Past Presidents

13. Recognition of Outgoing Council and Committee Chairs

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

15. Consideration of Late Reports and Resolutions

16. Moment of Silence for Deceased Physicians

17. Announcements

18. Recess for Reference Committee Hearings

Revised

TEXAS MEDICAL ASSOCIATION
2018 HOUSE OF DELEGATES ANNUAL SESSION

REGULAR SESSION
Saturday, May 19, 8:30 am, Expo Hall, Level 2, JW Marriott San Antonio Hill Country Resort and Spa
(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
   Leah H. Jacobson, MD, Chair

3. Announcements

4. Presentation of TMA-Established Organizations (video-taped)
   Texas Medical Liability Trust
      Robert D. Donohoe, President and CEO
   TEXPAC
      Robert J. Rogers, MD, Chair, Board of Directors
   Texas Medical Association Foundation
      Leslie H. Secrest, MD, President

5. Distinguished Service Award (9:15 am)
   Surendra K. Varma, MD, Lubbock

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

Revised for Supplement
Late Item Distributed at Meeting.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
ORDER OF BUSINESS
2018 ANNUAL SESSION
May 18-19, 2018

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

REPORTS:	**REFERRED TO:**
1. Report of President	
1. Physician-Led Initiatives to Address Maternal Mortality and Morbidity	*SOCIO*
2. Reports of Speakers	
1. Transparency in Election in the House of Delegates (Resolution 109-A-17)	*FOA*
2. Election of TMA Board of Trustees Members, Filling Vacancies by Special Election (Resolution 101-A-17)	FOA
3. Reports of Board of Trustees	
1. TMA Leadership College	Informational
2. Disclosure of Affiliations	Informational
3. Hurricane Harvey Disaster Relief	Informational
4. TMAIT, TMFHQI, and TMLT	Informational
5. Pending Lawsuits Involving Texas Medical Association	Informational
6. Investments	Informational
7. TMA/THA Physician Medicaid Rate Improvement Task Force	Informational
8. Audit of 2016 Financial Statements and 2017-18 Operating Budgets	Informational
9. 2017-18 Board Officers and Committees	Informational
10. Medical Student and Resident Physician Loan Funds	Informational
11. Minority Scholarship Program	Informational
12. Sunset Review of TMA Standing Committees	*FOA*
13. Policy Review	FOA
14. TMA 2025	FOA
15. Amendments to Constitution and Bylaws Chapter 9, Councils	FOA
4. Report of Executive Vice President	
1. 2017-18 Update	Informational
5. Report of Interspecialty Society Committee (no report)	
6. Report of Committee on Membership	
1. Membership Development	Informational
7. Reports of Board of Councilors	
1. Distinguished Service Award — Surendra K. Varma, MD	Informational
2. Opinions of the Board of Councilors	Informational
3. County Medical Societies	Informational
4. Support of Evidence-Based Medicine (Resolution 107-A-17)	FOA
5. Emeritus Nominations	FOA
6. Honorary Nominations	FOA
7. Policy Review	FOA

8. Reports of Committee on Physician Health and Wellness
1. 2018 Goals; PHR Assistance Fund; Drug Screen Program — Informational
2. Continuing Medical Education Programs — Informational
3. Treatment Facilities; Medical Student and Resident Activities — Informational

9. Reports of Texas Delegation to the AMA
1. AMA House of Delegates Meetings in 2017 — Informational
2. AMA Membership, Representation, and Delegation Leadership — Informational
3. Texas Delegation Operating Procedure Changes — FOA

10. Report of International Medical Graduate Section
1. Displaced and Refugee Physicians in Texas and Potential TMA Outreach (Resolution 105-A-17) — Informational

11. Report of Medical Student Section
1. Medical Student Section Operating Procedures Update — FOA

12. Report of Resident and Fellow Section (no report)

13. Report of Young Physician Section
1. Young Physician Section Operating Procedures Update — FOA

14. Reports of Council on Constitution and Bylaws
1. Amendments to the TMA Constitution — FOA
2. Election of TMA Board of Trustees Members, Filling Vacancies by Special Election (Resolution 101-A-17) — FOA

15. Reports of Council on Health Care Quality
1. Quality Update — Informational
2. Policy Review — MEHCQ

16. Report of Council on Health Promotion (no report)

17. Reports of Council on Health Service Organizations
1. Policy Review — SOCIO
2. Medical Staff Rights and Responsibilities Bill of Rights — SOCIO
3. Due Process Rights in Physician Contracts With Hospitals — SOCIO

18. Report of Council on Legislation (no report)

19. Reports of Council on Medical Education
1. Addressing Physician Mental Health Status Disclosures (Resolution 111-A-17) — Informational
2. Policy Review — MEHCQ
3. Aligning Future Graduate Medical Education Capacity With Target Enrollments of New Texas Medical Schools — MEHCQ
4. Physician Representation on Texas Higher Education Coordinating Board — MEHCQ

20. Reports of Committee on Continuing Education
1. TMA CME Program Update — Informational
2. Policy Review — MEHCQ

21. Reports of Committee on Physician Distribution and Health Care Access
1. Annual Physician Workforce Update — Informational
2. Policy Review — MEHCQ

22. Reports of Council on Practice Management Services
1. Reducing Errors in Pharmacy (Resolution 307-A-17) MEHCQ
2. HIT Policy Review and New Cyber Security Policy MEHCQ

23. Reports of Council on Science and Public Health
1. Rejection of Discrimination (Resolution 304-A-17) FOA
2. Addressing the Diaper Gap (Resolution 305-A-17) SPH
3. Vitamin D3 Supplementation (Resolution 320-A-17) SPH
4. Implementing a Sugar-Sweetened Beverage Tax in Texas (Resolution 312-A-17) SPH
5. Policy Review SPH
6. Physician Role in Increasing Vaccination for HPV SPH
7. Evidence-Based Management of Substance Use Disorders SPH
8. Improving EHR, HIE, and other HIT Products to Address Issues of Sex and Gender SPH

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

25. Reports of Committee on Child and Adolescent Health
1. Policy Review SPH
2. Referred 2017 Resolutions Relating to Concussions and Head Injuries SPH

26. Report of Committee on Emergency Medical Services and Trauma
1. Committee Activities Update Informational
2. *Policy Review* *SOCIO*

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

28. Report of Committee on Reproductive, Women's, and Perinatal Health
1. Evaluation and Management of Stillbirth SPH

29. Reports of Council on Socioeconomics
1. Policy Review SOCIO
2. Geographic Practice Cost Indices Policy SOCIO
3. *Transparency and Payments for Prior Authorizations (Resolution 406-A-17)* *SOCIO*
4. *Compensation of Physicians for Authorizations and Preauthorizations (Resolution 408-A-17)* *SOCIO*
5. *Clearer Language Regarding the Physician's Role in Providing Auxiliary Aid for Effective Communication Under Current Federal Laws (Resolution 411-A-17)* *SOCIO*
6. *Medicaid Work Requirements* *SOCIO*

30. Report of Committee on Medical Home and Primary Care
1. Committee Activities Update Informational
2. *Policy Review* *SOCIO*

31. Reports of Patient-Physician Advocacy Committee
1. Patient-Physician Advocacy Update Informational
2. Review of Policy 265.019 Disruptive Behavior Standard FOA

32. Report of Committee on Rural Health
1. Committee Activities Update Informational

33. Report of TEXPAC
1. TEXPAC March Primary Summary Report Informational

34. Report of Texas Medical Association Insurance Trust
1. Texas Medical Association Insurance Trust 2017 Annual Report — Informational

35. Report of Texas Medical Association Foundation
1. Texas Medical Association Foundation 2017 Annual Report — Informational

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

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

RESOLUTIONS: **REFERRED TO:**

101. Patient-Centered Medical Record Responsibilities — FOA
Webb-Zapata-Jim Hogg County Medical Society
103. Internet-Based Notification of Patients When a Physician Is Closing or Leaving a Practice — FOA
Travis County Medical Society
104. Clarification of Guidelines for Online Prescribers in Texas — FOA
Travis County Medical Society
105. Revision of Section 165.155 (a) of the Texas Occupations Code, Solicitation of Patients — FOA
Bexar County Medical Society
106. Creation of a TMA Ad Hoc Committee on the Power and Influence of the Texas Nonprofit Health Corporation/501(a) Organization — FOA
Bexar County Medical Society
107. Physician Protections When Reporting Violations of Non-profit Health Corporations — FOA
Harris County Medical Society
108. Inclusion of Medical Students in Good Samaritan Laws and Policies for Disaster Settings — FOA
Medical Student Section
109. Liability Exemptions for Volunteer Medical Health Workers — FOA
Harris County Medical Society
201. Incorporating High-Value Care into Undergraduate and Graduate Medical Education in Texas — MEHCQ
Medical Student Section
202. Addressing Gender Bias in Undergraduate Medical Education with Implicit Bias Training — MEHCQ
Medical Student Section
203. Freedom from Maintenance of Certification — MEHCQ
Ori Z. Hampel, MD
204. Creating a Non-Profit Texas Board of Medical Specialties — MEHCQ
Smith County Medical Society
205. Graduate Associate Physicians — MEHCQ
International Medical Graduates Section
301. Synthetic Cannabis Educational Resources for Providers — SPH
Medical Student Section
302. Appropriate Physician Oversight of EMS Medical Practices — SPH
Travis County Medical Society
303. "Bathroom" Bills — SPH
Harris County Medical Society
304. Improving the LGBTQI+ Patient Health Care Experience — SPH
Medical Student Section
305. Addressing Food Deserts in Texas — SPH
Medical Student Section
306. Addressing HB 3859 – A Misstep in the Protection of Foster Care Children — SPH
Medical Student Section
307. Restriction of Provisions of HB 2561 to Schedule II Drugs — SPH
Bexar County Medical Society

308. Texas Prescription Drug Monitoring Program Data Integration into EHR Technology SPH
Medical Student Section
309. Implementing Blood Glucose Screening in Texas Schools SPH
Medical Student Section
310. Community Health Workers and HPV Vaccination SPH
Medical Student Section
311. Encouraging Unstructured Playtime in School SPH
Medical Student Section
312. Identification Bracelets for Patients with Hearing Loss SPH
Tarrant County Medical Society
313. Raising the Minimum Purchase Age for All Guns to 21 SPH
Ryan Van Ramshorst, MD, Texas Pediatric Society
314. Extreme Risk Protection Order and Gun Violence SPH
Ryan Van Ramshorst, MD, Texas Pediatric Society
401. Physicians Allowed To Delegate Ability to Enter EHR Data SOCIO
McLennan County Medical Society
402. Opposition to Medicaid Work Requirements SOCIO
Ryan Van Ramshorst, MD, Texas Pediatric Society
403. Under-Reporting of Optometric Diabetic Eye Examinations to Treating Physicians SOCIO
Harris County Medical Society
404. Opposition to Pain Score as Contributor to Hospital Financial Incentives SOCIO
Medical Student Section
405. Compensation to Physicians for Authorizations and Preauthorizations SOCIO
Ori Z. Hampel, MD
406. Supporting the Reclassification of Complex Rehabilitation Technology SOCIO
Resident and Fellow Section
<u>407. Medical Necessity Decisions Are the Practice of Medicine SOCIO</u>
<u>Harris County Medical Society (formerly 110)</u>
<u>408. Protecting the Prudent Layperson Standard SOCIO</u>
<u>Carrie de Moor, MD</u>
<u>Collin-Fannin County Medical Society</u>
<u>Nueces County Medical Society</u>
<u>Heidi Knowles, MD, Texas College of Emergency Physicians</u>

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
2018 Annual Session
INFORMATIONAL REPORTS

Reports of Board of Trustees
1. TMA Leadership College
2. Disclosure of Affiliations
3. Hurricane Harvey Disaster Relief
4. TMAIT, TMFHQI, and TMLT
5. Pending Lawsuits Involving Texas Medical Association
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7. TMA/THA Physician Medicaid Rate Improvement Task Force
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Report of Executive Vice President
1. 2017-18 Update

Report of Committee on Membership
1. Membership Development

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1. Displaced and Refugee Physicians in Texas and Potential TMA Outreach (Resolution 105-A-17)

Report of Council on Health Care Quality
1. Quality Update

Report of Council on Medical Education
1. Addressing Physician Mental Health Status Disclosures (Resolution 111-A-17)

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

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

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

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

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

Report of Committee on Rural Health
1. Committee Activities Update

Report of TEXPAC
1. TEXPAC March Primary Summary Report

Report of Texas Medical Association Insurance Trust
1. TMAIT 2017 Annual Report

Report of Texas Medical Association Foundation
1. Texas Medical Association Foundation 2017 Annual Report

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

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

REPORT OF BOARD OF TRUSTEES

BOT Report 1-A-18

Subject: TMA Leadership College

Presented by: David N. Henkes, MD, Chair

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

This successful program, now in its eighth year, boasts 137 alumni. Eighty-seven graduates are currently serving in TMA leadership via councils, committees, and sections with others representing their county and specialty societies. These physicians serve as thought leaders who can close the divide among clinicians and health care policymakers, and serve as trusted leaders in their local communities.

Participants must be active TMA physician members, 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 2019
Applications for the 2018-19 program are due by **June 8, 2018**. Visit www.texmed.org/leadership for more information and to download the application. For questions, contact Christina Shepherd at leadershipcollege@texmed.org, or call (800) 880-1300, ext. 1443.

Class of 2018 Curriculum

Live Session Topics
- Acts of Leadership
- Emotional Intelligence
- Personal Leadership
- Team Interaction and Development
- Building Mentor Relationships
- Personal Branding
- Using Social Media as a Thought Leader
- Legislative Process
- Advocacy in Action
- Media Training
- Physician Stress and Burnout
- Mindfulness and Meditation
- Communicating Across Barriers
- Art of Negotiation

Self-Study: Scholar Project
Scholars select from a comprehensive menu of project suggestions or create a project of their own that complements lessons/topics discussed.

Congratulations Class of 2018!
Twenty-three scholars will graduate during a luncheon ceremony held at TexMed 2018 on Saturday, May 19.

Scholar	Specialty	Sponsored By
Alexander Alvarez, MD	AL	Travis County Medical Society
Jaya Amaram-Davila, MD	IM	MD Anderson
Brian Boies, MD	AN	Bexar County Medical Society
Shanna Combs, MD	OBG	Tarrant County Medical Society
Allen Flack, MD	PTH	Wichita County Medical Society
Aakash Gajjar, MD	CRS	Galveston County Medical Society
Laura Faye Gephart, MD, MBA	OBG	Hidalgo-Starr County Medical Society
Samantha Goodman, MD	IM	Big Country Medical Society
Angela Guerra, MD	FM	Harris County Medical Society
James Halgrimson, DO	P	Travis County Medical Society
John Hinchey, MD	ORS	Texas Orthopaedic Association
Ifeyinwa Ifeanyi-Pillette, MD	AN	Harris County Medical Society

1	Michael Kim, MD	AN	Texas Society of Anesthesiologists
2	Monica Lee, MD	EM	Bexar County Medical Society
3	Maria Monge, MD	ADL	Texas Pediatric Society
4	Erika Munch, MD	REN	Bexar County Medical Society
5	Rupesh Nigam, MD	IM	Texas Chapter of the American Academy of Physicians
6	Jeffery Pinnow, MD	EM	Ector County Medical Society
7	Holli Sadler, MD	IM	Travis County Medical Society
8	Shaina Sheppard, MD	ACA	Harris County Medical Society
9	Susanna Spence, MD	R	Texas Radiology Society
10	Elizabeth Truong, MD	P	Texas Society of Psychiatric Physicians
11	January Tsai, MD	ACA	Texas Society of Anesthesiologists

REPORT OF BOARD OF TRUSTEES

BOT Report 2-A-18

Subject: Disclosure of Affiliations

Presented by: David N. Henkes, MD, Chair

In May 2006, the House of Delegates adopted Board of Trustees Report 18-A-06 as amended to read as follows:

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

At its January 2011 meeting, the Board of Trustees amended the disclosure form to require 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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AllCare Physicians Group Board of Directors
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Richard W. Snyder, MD

Code 3 Emergency Partners, LLC
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Code 3 Emergency Physicians
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Doctors Hospital at Renaissance
Carlos J. Cardenas, MD (B, C, and D)

Don R. Read, MD, PA
Don R. Read, MD (A, B, C, and D)

Emerus Community Hospital
Diana L. Fite, MD

Frost Bank McAllen Advisory Board
Carlos J. Cardenas, MD

HeartPlace, PA
Richard W. Snyder, MD

Houston Community College
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Arlo F. Weltge, MD

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OptumInsight
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Pathology Reference Laboratory
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Renaissance Medical Foundation
Carlos J. Cardenas, MD (B and C)

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Texas Institute of Health Care Quality and Efficiency
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Texas Medical Foundation Health Quality Institute
Gary W. Floyd, MD

Texas Medical Home Initiative
Sue S. Bornstein, MD

Texas Medical Liability Trust
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G. Ray Callas, MD (D)
Carrie de Moor, MD
Don R. Read, MD

Texas Osteopathic Medical Association
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Texoma Independent Physicians
Susan M. Strate, MD

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

VaxCare
Dougles W. Curran, MD (D)

Workforce Solutions Board of Directors
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Bailey Square Surgery Center
Northwest Surgery Center

Sue S. Bornstein, MD
American College of Physicians
Blue Cross/Blue Shield (D)
PathAdvantage Associated
Texas Medical Home Initiative

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St. Joseph Medical Center (D)
Texas Medical Liability Trust (D)

G. Ray Callas, MD
AllCare Physicians Group Board of Directors (D)
American Board of Anesthesiology
American Society of Anesthesiologists
Anesthesia Associates (D)
Beaumont Chamber of Commerce
Blue Cross Blue Shield (D)
Kare Infusion Center (C and D)
Mallinckrodt Pharmaceuticals (D)
Texas Department of Licensure and Regulations
Texas Medical Liability Trust (D)
Texas Society of Anesthesiologists (C and D)

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Renaissance Gastroenterology Institute (B and C)
Renaissance Medical Foundation (B and C)
Renaissance Outpatient Rehabilitation Institute DBA Kids Korner (B and C)
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Workforce Solutions Board of Directors

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Blue Cross Blue Shield (D)
Lakeland Medical Associates
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VaxCare (D)

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Central Texas Colon & Rectal Surgeons
Texas Health Services Authority

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

Arlo F. Weltge, MD
American College of Emergency Physicians
American Medical Response
Houston Community College
University of Texas Medical School at Houston

REPORT OF BOARD OF TRUSTEES

BOT Report 3-A-18

Subject: Hurricane Harvey Disaster Relief

Presented by: David N. Henkes, MD, Chair

The TMA Board of Trustees established a TMA Family of Medicine Disaster Relief Program in 2005 to provide grants to physician practices affected by a disaster. The board approved (1) that the Trustees of The Physicians' Benevolent Fund (PBF) designate a "Natural Disaster Relief Fund" account within the PBF to receive funds intended for grants to Texas physicians; and (2) that the Trustees of PBF appoint a committee responsible for reviewing grant requests and recommend appropriate action to the Trustees.

Members of the TMA Board of Trustees and the Trustees of PBF, along with advisors who live in designated disaster areas, were asked to serve on the committee and provide grant application reviews and recommendations for awarding funds to physicians in need. The need arose in 2005 following Hurricane Rita and again in 2008 for Hurricane Ike. The PBF Committee on Hurricane Harvey Disaster Relief was put into action immediately following the occurrence of Hurricane Harvey in August 2017.

Members of the Hurricane Harvey Disaster Relief Committee represented TMA leadership, PBF leadership, and physicians in the affected areas:

- Don Read, MD, Chair and TMA Past President (Dallas)
- Mrs. Sue Bailey, PBF Chair (Austin) – second term
- Stephen Brotherton, MD, TMA Past President (Fort Worth) – third term
- Jerry Hunsaker, MD, TMA CMS Delegate (Corpus Christi)
- Austin King, MD, TMA Past President (Abilene)
- Mark Kubala, MD, TMA Past President and TMAF Advisory (Beaumont) – third term
- George Peterkin III, MD, PBF committee member (Houston)
- Jim Rohack, MD, TMA Past President (Galveston)

TMA executive staff immediately sought donations from large donors across the U.S. and implemented online collection abilities through TMA's website for collection via the TMA Foundation. As of Feb. 1, 2018, a total of $852,222 in cash donations had been received to support Texas physicians who encountered physical damages to their practices as a result of being in a federally declared disaster area. In addition to these funds, PBF Disaster Relief had a carryover/operating balance of $160,435 that it added to these funds for a current total of $1,012,657 available to help those needing it the most. Major contributions were received from:

Major Contributor(s)	**Donation(s)**
The Physicians Foundation	$500,000
American Medical Association	$150,000
Texas Individual Physicians & Donors	$26,362
AMA Foundation	$25,000
Marshfield Clinic Health System	$25,000
Massachusetts Medical Society	$25,000
California Individual Physicians & Donors	$21,980
Other State Individual Physicians & Donors	$16,730

California Medical Association	$10,000
Louisiana State Medical Society	$10,000
Rhode Island Medical Society	$10,000
Private Physician Organizations	$8,800
Harris County Medical Society	$5,000
Henry Schein Cares Foundation	$5,000
Michigan State Medical Society Foundation	$5,000
Dallas County Medical Society	$3,000
Other State Medical Associations & County Societies	$2,850
Louisiana and Massachusetts Society Alliances	$2,500

The committee met by conference call to review guidelines, application content, and to set future conference call dates. Those tasks were accomplished to provide financial assistance to physician practices that incurred physical damages due to Hurricane Harvey and to be good stewards of the funds raised for this purpose. Coordinated efforts also were made with TMA communications to promote the availability of the program. By Feb. 1, 2018, a total of $739,890 was disbursed to 53 medical practices (166 physicians and their 1,277 non-physician staff).

The intent is for the program to wrap up by March 2018. It appears that funds will be mostly exhausted by that time; there is no necessity to utilize all of the original PBF Disaster Relief carryover/operating balance.

REPORT OF BOARD OF TRUSTEES

BOT Report 4-A-18

Subject: TMAIT, TMFHQI, and TMLT

Presented by: David N. Henkes, 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 2018, no physician terms were expiring.

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 January 2018, the TMA Board of Trustees recommended Jorge A. Duchicela, MD, Weimar; Lisa L. Ehrlich, MD, Houston; and Wendy Parnell, MD, Dallas, for consideration on the ballot for Places 1 and 2; and Gary W. Floyd, MD, Keller, for reelection to Place 9.

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 2018, no physician terms were expiring.

REPORT OF BOARD OF TRUSTEES

BOT Report 5-A-18

Subject: Pending Lawsuits Involving Texas Medical Association

Presented by: David N. Henkes, MD, Chair

At each of its meetings, the Board of Trustees reviews an audit trail of pending lawsuits involving the association. The following is an updated report, prepared in January, by the Office of the General Counsel.

A. LITIGATION AS PLAINTIFF

1. *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 Aug. 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 Oct. 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 Feb. 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 Dec. 17, 2007. TBCE subsequently appealed the district court's order, denying its plea to the jurisdiction. On Nov. 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 Aug. 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 Aug. 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 Sept. 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 Jan. 28, 2011.

The court heard oral argument from both sides on Sept. 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 Sept. 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 Aug. 15, 2012. TBCE filed a response. The Supreme Court of Texas is not required to grant the Petition for Review.

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

TMA filed its Brief on the Merits on Feb. 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 3. TMA v. Texas Board of Chiropractic Examiners in which the diagnosis issue is raised.)*

2. *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 Feb. 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.

On Aug. 22, 2010, TMA filed its Second Amended Original Petition.

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 Oct. 19, 2012, the Defendants and Intervenor filed a Joint Response to TMA's Motion for Summary Judgment. On Nov. 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 Jan. 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 Jan. 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 Oct. 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 Dec. 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 Brief Filed 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 Aug. 6, 2015. TSBEMFT and TAMFT filed their brief on the Merits on Nov. 12, 2015. TMA filed a Response Brief on the Merits on Dec. 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 Jan. 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 Aug. 8, 2016, TSBEFMT's and TAMFT filed a Joint

Reply to Response Motion for Rehearing. On Sept. 2, 2016, the Court granted the Petition for Review. Oral arguments were made on Oct. 11, 2016.

On Feb. 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.

Following the Supreme Court's decision, the Texas Legislature in the 85th Regular Session passed H.B. 2818, which includes under the definition of "marriage and family therapy" the use of the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases. It provides that the practice of marriage and family therapy does not constitute the practice of medicine, and it excludes from the definition the prescribing of medication, the treating of a physical disease, or providing any service outside the scope of practice of a LMFT or LMFT associate.

3. ***TMA v. Texas Board of Chiropractic Examiners***
(Regarding scope of practice, specifically pertaining to vestibular-ocular-nystagmus (VON) testing)

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

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

TMA again submitted its strong objections in a comment letter on July 19, 2010. TBCE held a rule hearing pertaining to the rule on Aug. 6, 2010. At that rule hearing, Sara Austin MD, neurologist, testified on behalf of TMA. TBCE voted to adopt the rule, without any debate whatsoever. The final rule has been formally adopted.

Incidentally, at that TBCE hearing, the TBCE president stated that any discussion pertaining to scope of practice should be sent to one member through email, and not to all the board members, in order to avoid the "open meetings" rule. In light of that statement, on Aug. 25, 2010, TMA sent TBCE a Public Records Request under the authority of the Government Code, Section 552.021, for copies of all policy statements or interpretations of the law or rules that have been adopted,

published, or issued by the Texas Board of Chiropractic Examiners, or emails or other writings relating to scope of practice for chiropractors. TBCE produced some documents and withheld others, seeking an attorney general opinion pertaining to the documents withheld. TMA prepared a response letter to the attorney general, and the attorney general has ruled in TMA's favor. TBCE has since produced the documents it sought to withhold, which contain some information that is quite contrary to TBCE's position and very favorable to TMA's position. TMA's 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 Jan. 31, 2011.

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

TMA filed a Motion for Summary Judgment, and TBCE filed its own Motion for Summary Judgment. On Dec. 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.

TBCE filed its Reply Brief on Aug. 27, 2012. On Sept. 11, 2012, the court denied oral arguments and set the case for submission on briefs on Oct. 2, 2012.

On Nov. 21, 2012, the Court of Appeals issued its opinion reversing the trial court's ruling, which had granted TMA's Motion for Summary Judgment. The appellate court also remanded the case back to the trial court to determine what VON testing is. According to the appellate court, questions of fact 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 Sept. 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 Feb. 28, 2014, with respect to the issue of whether or not it is within the scope of practice for chiropractors to make a medical diagnosis. 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 Sept. 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 Oct. 31, 2014. On Dec. 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 Jan. 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 Feb. 23, 2015.

On May 21, 2015, TBCE filed a Petition for Review before the Supreme Court of Texas. TMA filed a Response to the Petition for Review on June 22, 2015. TBCE filed a Reply in Support of Petition for Review on July 10, 2015.

On Oct. 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 Aug. 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 Aug. 13, 2016.

On Oct. 19, 2016, Judge Hurley issued a Final Judgment declaring:

- The authorization for chiropractors to perform "Technological Instrumented Vestibular-Ocular-Nystagmus" exceeds the scope of chiropractic and is therefore void;
- The definition of "musculoskeletal system" to include "nerves" exceeds the scope of chiropractic and is therefore void;
- The definition of "subluxation complex" as a "neuromusculoskeletal condition" exceeds the scope of chiropractic and is therefore void; and
- The use of the term "diagnosis" as used by TBCE in its Scope of Practice Rule exceeds the scope of chiropractic and is therefore void.

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

In January 2017, TBCE filed an appeal with the Third Court of Appeals. TMA filed its brief in response to TBCE's brief on Sept. 11, 2017. The case is set for hearing before the appellate court on Feb. 28, 2018.

4. ***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

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 Nov. 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 Aug. 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 Aug. 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 Sept. 13, 2013, in this case in support of Dr. Benge's position, arguing that:

(1) The Texas Legislature set up a statutory scheme contained in Chapter 74 regarding informed consent claims.
(2) The legislature decided as a policy matter that most surgical procedures would have a particular and exclusive list of risks as delineated by the Texas Medical Disclosure Panel and that no other disclosures would be required in order to enjoy the benefits of the presumed informed consent.
(3) The experience levels of surgeons and residents are not on List "A" for laparoscopically assisted vaginal hysterectomy procedures, so Dr. Benge was under no duty to disclose that information.
(4) If this jury's verdict is upheld, it would have a significant impact on resident education as it would be impractical, if not impossible, to tell each patient in advance about which residents would be involved; what their education, training, and experience was with regard to that type of surgery; and exactly what they would be doing during the surgery.
(5) This could be a slippery slope: The next cause of action could be against primary surgeons for failing to tell patients about the limits of their own experience and training in a particular type of surgery.

The Court of Appeals for the First District of Texas in Houston issued its opinion on Nov. 18, 2014. The court found that there was no common law duty to disclose the relative experience of the surgeon assisting. The court found that the resident-disclosure theory did not concern a risk for hazard inherent to her hysterectomy surgery and that no such duty existed. The court found that the assertion of medical negligence that characterizes the failure to disclose this information

as a breach of duty was an invalid theory and should not have been submitted. As the court could not determine whether the jury found in favor of the plaintiff on this theory as opposed to some other valid theory, the court concluded that it was required to order a new trial.

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

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

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

Both parties filed Petitions for Review before the Supreme Court of Texas on filed Dec. 7, 2015. The plaintiff waived filing a response unless requested by the court on Dec. 8, 2015. The defendants filed a Response to the Cross-Petition for Review on Feb. 5, 2016. Plaintiff's filed a Response to Petition for Review on May 11, 2016. Dr. Benge filed Reply to Response to Petition for Review on June 27, 2016.

On Sept. 2, 2016 the Supreme Court of Texas requested briefs on the merits from both parties. Both sides filed Briefs on the Merits on Nov. 9, 2016. Dr. Benge and Kelsey-Seybold filed a Merits Brief as Cross-Respondents on Dec. 29, 2016. Ms. Williams filed a Response to Petitioners' Brief on the Merits on Dec. 29, 2016. On Feb. 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 were made on Jan. 11, 2018.

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

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

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

A jury trial in the case was held from March 17, 2017 through March 27, 2017. The jury deliberated for 2 days and delivered its verdict on March 29, 2017. The jury found that MH defamed Dr. Gomez and awarded Dr. Gomez $6.4 million, including $1 million in punitive damages. In May 2017, the state district court judge, who presided over the trial, affirmed the jury verdict by entering an order in Dr. Gomez's favor that awarded over $6 million in damages. A notice of appeal was filed on Aug., 10, 2017. A post-judgment mediation was unsuccessful.

3. *Teladoc, Inc., et al. v. Texas Medical Board, et al.*
(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 Aug. 4, 2015. TMB filed a reply to the petition on Aug. 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 Aug. 25, 2015. TMB filed its Reply in Support of Amended Motion to Dismiss on Sept. 25, 2015. Teladoc filed a

Supplemental Response to Defendants' Amended Motion to Dismiss on Oct. 23, 2015. TMB filed a Reply to Plaintiff's Supplemental Response on Oct. 27, 2015.

On Dec. 14, 2015, Judge Pitman denied TMB's Amended Motion to Dismiss. On Jan. 8, 2016, TMB filed Notice of Appeal to the 5th Circuit Court of Appeals. Trial proceeding have been stayed pending appeal. A trial is tentatively scheduled to begin Feb. 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 Aug. 15, 2016, Judge Pitman issued an order denying the Motion to Certify Order for Appeal.

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

On Oct. 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 Nov. 8, 2016. On Nov. 2, 2016, all parties submitted a Joint Motion to Stay the proceeding until April 19, 2017. On Nov. 4, 2016, Judge Pitman granted the motion to stay until April 19, 2017. The issue of the proper scope and laws governing telemedicine in Texas was before the Texas legislature. Hence, both parties sought and obtained an extension of the stay until Sept. 1, 2017. A new Texas telemedicine law was enacted in April 2017 and draft rules have been proposed by TMB. TMA participated a TMB stakeholder meeting on this topic commenting on the preliminary draft of the rules.

The TMB adopted rules to be effective on Nov. 26, 2017 in accordance with the new telemedicine law. Once the rules became finally adopted, Teladoc and the TMB stipulated to a dismissal with prejudice on Nov. 29, 2017. The stipulation was approved by the court a few days later, bringing the lawsuit to a close.

4. *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 Dec. 1, 2015, submitted an amicus brief to the appellate court, wherein TMA argued that TBCE went too far in allowing chiropractors to perform acupuncture. TMA asked for a reversal of the trial court's judgment, as doing so would invalidate the relevant rules of the chiropractic board.

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

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

The 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 Oct. 4, 2016. The Texas Board of Chiropractors Examiners filed its response on Dec. 29, 2016. TAAOM filed a reply on Jan. 10, 2017.

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

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

5. ***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***
(Regarding whether Texas Civil Practice and Remedies Code §74.153 applies to emergency medical care provided in an obstetrical unit without the patient first having been evaluated in a hospital emergency department.)

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

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

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

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

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

On May 2, 2017, a Petition for Review was filed by the defendants. On May 9, 2017, the Supreme Court of Texas requested a response to the Petition for Review. On July 10, 2017, a Response to the Petition for Review was filed. A Reply to the Response to the Petition for Review was filed on Aug. 24, 2017. On Sept. 22, 2017 the Court requested briefs on the merits from all parties. A Brief on the Merits was filed Nov. 22, 2017. A Response Brief was due Jan. 11, 2018 and a Reply Brief was due Jan. 26, 2018.

6. ***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 Dec. 30, 2016, Dr. Nguyen filed a Petition for Writ of Mandamus with the Supreme Court of Texas.

Result: On Jan. 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 Feb. 3, 2017, the Supreme Court of Texas 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 Reply to the Petition for Writ of Mandamus was filed on March 15, 2017.

On March 31, 2017, the Supreme Court of Texas requested briefs on the merits from all parties. On May 1, 2017, Dr. Nguyen filed a Brief on the Merits. On May 22, 2017, a Brief on the Merits was filed by the Real Party in Interest. On June 6, 2017, a Reply Brief was filed by Dr. Nguyen. The Court has not yet ruled on the Petition for Writ of Mandamus. On Sept. 1, 2017 the Petition for Writ of Mandamus was denied. A Motion for Rehearing was filed on Sept. 15, 2017. The Motion for Rehearing was denied on Oct. 20, 2017.

7. *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 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 Feb. 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.

On June 16, 2017, the Supreme Court decided in favor of the defendants, holding that the defendants were entitled to summary judgment on all of the plaintiff's claims. The court did not address whether Dr. Hansen was entitled to due process procedures under regulations of the Texas Medical Board because he did not present those at the trial level.

On July 26, 2017, Dr. Hansen filed for a motion for rehearing. On Aug. 14, 2017, TMA filed an amicus letter that reemphasized the importance of due process in ensuring that non-profit health corporations do not take adverse action against physicians without due process (as required by

TMB rules) so that physicians are free to do what is best for their patients, exercising their independent professional medical judgment.

On Sept. 22, 2017, the court denied Dr. Hansen's motion for rehearing, finally reinstating the trial court's take-nothing judgments in favor of defendants.

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

(Regarding whether a physician who met the standard of care, but came to a finding that was later changed, can be held liable for the earlier finding)

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

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

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

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

The case is pending before the Fifth Circuit. Oral arguments were heard before the court on Dec. 6, 2017.

9. ***Leah Anne Gonski Marino, M.D. v. Shirley Lenoir***
(Regarding whether a medical resident employed by a governmental entity was entitled to governmental immunity though the resident was performing clinical duties at a facility that was not owned or operated by the employer)

A medical resident employed by the University of Texas System Medical Foundation ("Foundation") was appointed to the residency program sponsored by the University of Texas Health Science Center at Houston ("UTHSCH"). The resident was treating patients as a required part of her training at the University of Texas Physicians Clinic. The Clinic was staffed by UTHSCH physician faculty and residents, but it was not a hospital or facility operated by the Foundation. The resident treated a patient at the Clinic, and the patient later sued the resident and the attending physician, who was an employee of UTHSCH, for health care liability claims.

The defendants both filed for dismissal of the complaint under a state law that provides dismissal for an individual governmental employee if the complaint could have been brought against the government employer. The trial court found that dismissing the suit was proper.

On appeal, the appellate court affirmed the attending physician's dismissal but reversed the resident's dismissal. The reasoning behind the reversal of the dismissal as to the resident was the resident's employer did not have the legal right to control the resident when she was assigned to the Clinic. The appellate court found that the Foundation had disavowed itself of legal control of the resident and she was thus not an "employee."

The appellate court's reasoning was based in large part on the Foundation's bylaws, which states that a physician employed by the Foundation but serving at another hospital is subject to the "direction and control" of that hospital, and that other hospitals must agree to "assume full responsibility for the direction and control" of the acts of a Foundation-employed physician while serving at the hospital.

Result: On April 25, 2017, TMA filed an amicus brief with TAPA, the Texas Osteopathic Medical Association, and the Texas Hospital association arguing that the Foundation still maintained the legal right to control its resident-employees and further, that the appellate court's result would disrupt graduate medical education in Texas because of how frequently employed residents have clinical rotations among different facilities.

On April 28, 2017, the Supreme Court affirmed the appellate court's decision, finding that the medical resident failed to establish that she was an employee of the foundation because under relevant documents and in actual practice, the details of her day-to-day tasks were controlled by UTHSCH and its physicians, not the Foundation, which merely paid Gonski and performed certain routine administrative functions on her behalf.

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

In this case, the Perkins family is suing physicians and the Children's Medical Center of Dallas (CMCD) as representatives of their deceased 16-year old son who had sought care at CMCD for a brain tumor associated with primary CNS lymphoma. The plaintiffs allege that though the surgery

was successful, the follow-up treatment failed to meet the standard of care on the basis that physicians employed experimental protocols designed to treat patients with severe systemic disease, which they claim their son did not have. The plaintiffs allege that other physicians failed to recognize and remove their son from this improper protocol. And finally, they allege that another physician failed to keep their son on medication for his lungs for the proper amount of time and failed to scan the son's chest prior to discharge.

The issue, though, is that the defendant-physicians were employees of UT Southwestern at Dallas ("UTSW")—a governmental entity—and as such, would ordinarily be afforded governmental immunity under the Texas Tort Claims Act. As a result of the 20O3 tort reforms pushed through by TMA, the Act entitles a Texas governmental entity physician employee to be dismissed from a lawsuit if the employer could have been sued in the employee's place.

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

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

Result: TMA and TAPA have agreed to file an amicus brief in the case which was filed in February 2018.

11. *Gunn v McCoy*.

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

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

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

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

Legal Procedural History

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

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

D. TMA COMMENTS ON REGULATORY ISSUES

1. *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 Jan. 20, 2017 *Texas Register*.

On Aug. 4, 2017, the TMB notified stakeholders that it would be proposing rules relating to the informal settlement conference, and invited stakeholders to participate in a stakeholder's meeting to discuss the rules. TMA provided oral comments on the draft proposed rules. The TMB indicated that it would be formally proposing rules in Fall 2017. *(See also E. TMA Comments on Regulatory Issues 4. Texas Medical Board Proposed Rules Relating to Telemedicine.)*

2. *Texas Medical Board Stakeholder Group Working Draft Rules concerning Telemedicine*

Following the enactment of Senate Bill 1107 relating to telemedicine, the TMB proposed revisions to its rules regulating the practice of telemedicine and invited stakeholders to comment and participate in a stakeholder meeting. TMA provided oral comments at the July 17, 2017 stakeholder meeting and followed up with written comments submitted on Aug. 21, 2017. TMA's expressed support for the changes but also expressed concern that some rule changes eliminated regulations that provided guidance on enforcement for providers and provided guardrails that enhanced patient safety. TMA also commented that the revised rules needed further amendment to clarify requirements on privacy notice and the distinction among certain terms the rules use, and also raised certain questions regarding the TMB's intent behind certain rule changes.

Result: It is expected that the TMB will formally propose rules after its board meeting on Aug. 25, 2017. TMA will continue to monitor the development of the rules. *(See also E. TMA Comments on Regulatory Issues 5. Texas Medical Board Proposed Rules Relating to Informal Settlement Conferences.)*

3. *Texas Medical Board Proposed Rules Relating to Telemedicine (22 Tex. Admin. Code §§174.1-174.8, §174.9, §178.3, and §190.8)*

The Texas Medical Board formally proposed rules in response to Senate Bill 1107 (85th Regular Session, 2017) on Sept. 15, 2017. TMA provided comment on working drafts of the proposed rules, yet the proposed rules did not contain any changes since TMA had last provided comment. The proposed rules eliminated much of the existing regulation on telemedicine in favor of basic guidelines that largely echoed state law.

TMA's comment letter expressed general support for reducing the regulatory footprint on telemedicine medical services but also expressed concern that the rules may not adequate implement S.B. 1107 and that the rules are not reader friendly. The proposed rules continued to reflect the TMB's position on rulemaking that rules do not need to restate the law but merely supplement it. In the telemedicine context, TMA commented that this approach could cause confusion and forces readers to flip between rules and the law. The result was a 22-page letter that identified ways in which the TMB could make the proposed rules more clear and could more completely implement S.B. 1107.

Result: The TMB adopted the proposed rules on Nov. 26, 2017 with minimal change from the proposed version. Both at the board meeting at which the rules were presented for adoption and in the formal publication of the adoption, the TMB represented that TMA "fully supported" the proposed rules and recommended "no changes." The TMB made insignificant changes in response to TMA's comment letter.

4. ***Texas Medical Board Proposed Rules Relating to Informal Settlement Conferences (22 Tex. Admin. Code §§187.16 and 187.18)***

The Texas Medical Board proposed rules relating to Informal Settlement Conferences (ISC) that were intended to ensure conformity with the underlying statute and legislative intent. The proposed rules eliminated many parts of the existing rule, especially parts that added formality to the ISC process.

TMA submitted comments that supported the TMB's effort to ensure the ISC process was fair and transparent. TMA did express, though, that the process could be made even more transparent and the rules could be modified in a way that could aid in compliance. Specifically, the proposed rules proposed to eliminate a requirement that the TMB send a licensee an explanation of the ISC process. TMA commented that this should not be eliminated because this is helpful information that can foster transparency and actually assist in efficient resolution of investigations. TMA suggested other changes to the rule that would help the reader understand the ISC process.

Result: On Nov. 17, 2017, the TMB published a final version of the rules to be effective on Nov. 26, 2017. The TMB did make some changes in accordance with TMA comments. Notably, the TMB did not agree to keep a requirement to send a licensee information on the ISC process because, according to the TMB's position, the process is sufficiently laid out in board rule. The TMB did make other non-substantive changes to make the rule slightly clearer and reader friendly.

5. ***Texas Medical Board Proposed Rules Related to Pain Management Clinic Inspections (22 Tex. Admin. Code §195.3)***

The 85th Legislature authorized the TMB to conduct inspections of clinics on the basis that the clinic should have, but did not, obtain certification as a pain management clinic. (Generally, a pain management clinic is one a majority of the patients of which receive a monthly prescription for opioids, benzodiazepine, barbiturates, or carisoprodol.) The TMB proposed rules that contained criteria for performing such an inspection. The proposed rules would allow the TMB to conduct an inspection if the board "suspects" that a clinic did not properly certify as a pain management clinic, and identified eight criteria that the TMB was to use evaluate clinics.

TMA and the Texas Academy of Family Physicians filed a letter expressing concern that the proposed rule was so broad that there would be significant unintended consequences. While the comments expressed support for the importance of identifying uncertified pain management clinics, the proposed rules were drafted in such a way that many unsuspecting clinics could be subject to needless inspections, adding administrative burden and interfering with patient care. The comments stated that the threshold in the proposed rules was far too low—instead of a subjective "suspicion" standard, the rules should adopt an objective, reasonable basis standard. Further, the comments expressed concern for most of the eight criteria identified in the proposed rule. Most of the criteria, as the comments explained, were not narrowly tailored to identifying uncertified pain management clinics.

Result: At the Dec. 8, 2017 board meeting, the TMB moved to adopt the rules with modification. The TMB did make some change according to comments received from TMA and other stakeholders. Most significantly, the TMB eliminated the "suspicion" standard and inspections should be based on a reasonable belief that a clinic did not properly receive certification. The TMB also modified some of the criteria, making the purpose slightly more narrowly tailored.

6. *Texas Medical Board Proposed Rules concerning the "Ten-Year Rule" (22 TAC §§ 163.7 and 172.4)*

The Texas Medical Board proposed the repeal of the "ten-year rule," which requires that an applicant for licensure have passed a licensure examination within the ten-year period preceding the filing date of the application. Correspondingly, the TMB proposed changes to several current rules that make reference to the ten-year rule (the corresponding rules relate to temporary and limited licenses).

Result: On Oct. 13, 2017, TMA submitted a comment letter in strong support of the repeal of the ten-year rule and in support of the proposed changes to the related rules. The TMB adopted the proposed rules without changes. The adopted rules were published in the *Texas Register* on Nov. 17, 2017.

7. *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. Vestibular-ocular-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 3. TMA v. Texas Board of Chiropractic Examiners.)*

8. *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 Aug. 1, 2014 *Texas Register*. A delegation from TMA met with TBN on Sept. 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. Legislation filed in the 2017 regular session of the Texas Legislature would have allowed APRNs to practice independently; that bill (H.B. 1415 by Rep. Stephanie Klick), and its companion (S.B. 681 by Sen. Kelly Hancock), both failed to pass. TMA opposed both bills.

9. ***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 Feb. 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 Supreme Court of Texas issued an opinion on Feb. 24, 2017 allowing the use of certain diagnostic codes. *(See also A. Litigation as Plaintiffs 2. TMA v. The Texas State Board of Examiners of Marriage and Family Therapists.)*

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

On Jan. 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 Registe*r. 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 Sept. 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 Oct. 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 Nov. 25, 2014. The lawsuit is still pending. *(See also A. Litigation as Plaintiffs 4. 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 emphasizes 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 is monitoring the enforcement of the new rules on sleep apnea.

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

In the Sept. 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 Dec. 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 Jan. 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 Jan. 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.

The Dental Board has proposed the repeal of rules regarding the Blue Ribbon Panel, which was disbanded following the completion of its duties in January 2017. The proposed repeal was published in the *Texas Register* on Aug. 11, 2017. The Dental Board has concurrently proposed the establishment of a permanent Advisory Committee on Dental Anesthesia whose purpose will be to analyze and report on de-identified data and associated trends concerning anesthesia-related deaths or incidents in the dental setting. The proposal states that the advisory committee must include a licensed Texas physician anesthesiologist and five licensed Texas dentists. The Dental Board's final rule, published in the Oct. 13, 2017 Texas Register, contains language designating the inclusion of a licensed Texas physician anesthesiologist.on the advisory committee.

12. ***Texas Medical Disclosure Panel Proposed Rules concerning Informed Consent (25 TAC §601.2, §601.9)***

The Texas Medical Disclosure Panel proposed rules concerning informed consent in the use of anesthesia. The rules were published in the *Texas Register* on Aug. 18, 2017. The proposed rules added language regarding deep sedation, moderate sedation, and anesthesia risks for prenatal/early childhood anesthesia as relates to prolonged or repeated exposure to such

anesthesia and sedation during pregnancy and in early childhood. Corresponding changes were proposed for the English and Spanish versions of the Disclosure and Consent Form for Anesthesia.

Result: TMA submitted a letter on Sept. 18, 2017, in support of the proposed rules. The rules were adopted without changes. The adopted rules and related forms were published in the *Texas Register* on Dec. 22, 2017.

13. *Texas Department of Insurance Informal Working Draft Rules on HMOs, Including Network Adequacy and Out-of-Network Payment Provisions*

On Friday, Jan. 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 Oct. 7, 2016 *Texas Register*. TMA filed 101 pages of comments on a total proposed rewrite of the HMO rules on Nov. 7, 2016.

TDI adopted new HMO rules, which were published in the April 21, 2017 *Texas Register*.

14. *Texas Department of Insurance, Division of Workers' Compensation Informal Rule on Telemedicine*

Result: On Oct. 23, 2017, TMA submitted comments on TDI-DWC's informal rule proposal on telemedicine and telehealth services. TDI- DWC stated that its intent with the informal rule was to generally require physicians and other health care providers to follow applicable Medicare payment and billing policies when billing for telemedicine or telehealth services in the workers' compensation system, but to expand access to telemedicine and telehealth services in the workers' compensation system by removing the originating site and geographic restrictions imposed under the Medicare policies. TMA was generally supportive, in concept, of removing the geographic and originating site restrictions; however, TMA sought additional information on other provisions in the rule in order to obtain clarity on the intended scope and impact of the informal rule. TDI-DWC is expected to formally propose a telemedicine rule within the next month.

15. *Texas Department of Insurance Proposed Rules on Out-of-Network Claim Dispute Resolution*

Result: On Nov. 13, 2017, TMA submitted an 11-page comment letter on the Texas Department of Insurance (TDI) proposed rules on the out-of-network claim dispute resolution process. The purpose of the proposed rules was to update the existing rules to implement changes enacted under SB 507. TMA's comments on the proposed rules were largely directed at ensuring the rules: (1) conform to underlying statutory authority and (2) provide regulatory clarity to the out-of-network claim dispute resolution process. Additionally, TMA strongly opposed provisions of the rule proposal that referenced the facility-based provider or emergency are provider's notice requirements, as TDI does not have regulatory authority over these providers. TMA argued that, instead, the provider's obligations should be set forth in their respective licensing board's rules, not in TDI's rules.

16. *Texas Health and Human Services Commission Amendments to HHSC Medicaid Provider Agreement (effective Oct. 1, 2016) and Uniform Managed Care Contract Terms and Conditions (effective Sept. 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 Feb. 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 continues to monitor.

HHSC has not addressed the concerns that TMA and others have raised. HHSC has since made modifications to both the provider agreement and the UMCC, yet it has not made changes to address TMA's concerns.

17. ***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.

Result: 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 Sept. 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 Nov. 9, 2016.

TMA staff attended the Nov. 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 Dec. 9, 2016. On Dec. 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 Jan. 4, 2017 that he was delaying the start date of the rule for at least three weeks to consider his ruling. On Jan. 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.

In the 2017 regular session, the Texas Legislature passed a bill that requires a health care facility to dispose of embryonic and fetal tissue remains by interment, cremation, incineration followed by interment, or steam disinfection followed by interment. The bill, S.B. 8 by Sen. Charles Schwertner, also requires the Texas Department of State Health Services to establish and maintain a registry of participating funeral homes and cemeteries willing to provide free common burial or low-cost private burial, as well as private nonprofit organization willing to provide

financial assistance for costs associated with the burial or cremation of the embryonic and fetal tissue remains of an unborn child. The bill takes effect Sept. 1, 2017.

The Texas Department of State Health Services proposed rules which were published in the *Texas Register* on Nov. 17, 2017. The proposals related to the disposition of embryonic and fetal tissue remains by health care facilities, as provided for in S.B. 8. Among the key provisions is a requirement that embryonic and fetal tissue remains be disposed of through interment, cremation, incineration followed by interment, or steam disinfection followed by interment. The TMA Committee on Reproductive, Women's, and Perinatal Health submitted a comment letter on Dec. 18, 2017. In its letter, the Chair of the committee said that "[w]e recognize that some may seek information and support for burial or cremation and we do not take a position on that deeply personal matter. However, thousands of pregnancies in Texas end in a fetal loss each year. Nonetheless, we are unaware of any published research that identifies cremation or burial of embryonic and fetal tissue as a solution to a specific personal health or public health concern."

18. ***Department of State Health Services Proposed Rules Relating to Maternal Care Designations and Centers of Excellence for Fetal Diagnosis and Therapy (25 Tex. Admin. Code §§133.201-133.210, and §§133.221-133.226)***

The Department of State Health Services (DSHS) was directed by statute to develop hospital levels of care designations for maternal care and to adopt criteria for the identification of centers of excellence for fetal diagnosis and therapy. DSHS proposed rules identifying the criteria for the distinct levels of care and for the centers of excellence. Among the criteria were requirements that certain positions be filled by board certified physicians. The requirements did not specify whether the requirement was for initial board certification or whether physicians were required to maintain certification.

In light of Senate Bill 1148 (85th Legislature, 2017), which stated that certain hospitals could not require maintenance of certification absent certain exceptional circumstances, TMA commented to encourage DSHS to clarify the requirements in the proposed rules. More specifically, one of the exceptions that allows a hospital to requirement maintenance of certification is if the hospital does so in order to meet the requirements of a designation "under law," the standards for which specify a specific maintenance of certification requirement. TMA asserted that the underlying statute for the maternal care and fetal diagnosis designations did not specify a maintenance of certification requirement, so the DSHS rules were an insufficient basis for a hospital's requiring maintenance of certification. TMA expressed concern that hospitals would nevertheless seek to use DSHS rules to do just that.

TMA thus encouraged DSHS to clarify that its proposed rules required only initial board certification and that the rules could not be used as a basis for requiring maintenance of certification. TMA also pointed out that other current DSHS rules had similar requirements (e.g., the rules relating to stroke facilities required certain physicians to be filled by board certified physicians), and further encouraged DSHS to add the same clarification in those other rules as well.

Result: TMA submitted its comments on Dec. 20, 2017. DSHS has not adopted its proposed rules. TMA will continue to monitor the development of these rules.

19. ***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 Jan. 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.

According to the USP website, the USP <797> chapter concerning sterile compounding will be posted for a second round of public comments, "based on the nature and significance of the public comments [already] submitted to USP...". See http://www.usp.org/frequently-asked-questions/pharmaceutical-compounding-sterile-preparations. That date has not been announced.

The USP has announced that the "next revision to General Chapter <797> is anticipated to be published in the *Pharmacopeial Forum* 44(5) September/October 2018 for a second round of public comment and is expected to become official on Dec. 1, 2019." TMA staff will monitor the rulemaking process and solicit input from members once the proposed revisions are published.

20. *U.S. Food and Drug Administration Draft Guidance entitled "Insanitary Conditions at Compounding Facilities" (Docket No. FDA-2016-D-2268)*

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 Aug. 4, 2016 in the *Federal Register*. TMA on Oct. 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.

21. ***Issues Raised by the Texas Sunset Advisory Commission***

After the Texas Medical Board sunset bill failed to pass in the 85th Regular Session, on June 30, 2017, TMA sent a letter to the TMB outlining issues that were relevant to the TMB's sunset process that did not pass but that could still be accomplished through rulemaking under the board's existing authority.

These issues included (1) providing more and complete information to licensees prior to a licensee's informal settlement conference; (2) requiring that identifying information be redacted from expert physician reviewer reports; (3) requiring the board to provide a clearer statement of allegations when it notifies physicians of an investigation; and (4) requiring the board to provide a structure to receive and investigate complaints relating to nonprofit health corporations.

Result: The board has not disclosed any intention to adopt rules relating to TMA's issues. The board has asked for a stakeholder meeting in September 2017 to discuss issues relating to enforcement and there is a possibility that some of these issues will be on that agenda. TMA staff continues to monitor.

In November 2017, the TMB proposed rules that touched on an issue that TMA sought to address through rulemaking, and that was that relating to expert physician reviewer reports. The proposed rule modified existing rule so that an expert's report contained the expert's specialty area rather than the general qualifications. Notably, the proposed change would not require redaction of all identifying information but the expert's qualifications or specialty, nor would it require providing clearer statements of allegations or more and complete information to a licensee. The board moved to adopt the rule as proposed and it will take effect in early 2018.

22. ***Texas Sunset Advisory Commission Staff Review of the Texas Medical Board***.

The Texas Sunset Advisory Commission performed a statutorily required review of the Texas Medical Board in the 2015-2016 legislative interim, but because the bill making the statutory changes recommended by the Commission failed to pass, the legislature required the Commission staff to perform another review of the TMB during the 2017-2018 interim. Pursuant to that review, the Commission staff solicited comments on the scope of its review.

TMA provided comment expressing support for some of the statutory changes recommended by the Commission, including modifications relating to remedial plan requirements, increased information sharing in informal settlement conferences, and reciprocal medical licensure. TMA also recommended that the Sunset Commission staff evaluate additional aspects of the TMB, including expedited resolution following temporary suspensions or restrictions, removal of remedial plan information from a physician's profile, and complaint and investigation processes for nonprofit health corporations.

Result: It is expected that the Sunset staff will issue its report on the TMB in early 2018. TMA staff will continue to monitor the Sunset evaluation process.

REPORT OF BOARD OF TRUSTEES

BOT Report 6-A-18

Subject: Investments

Presented by: David N. Henkes, MD, Chair

TMA and Separate Fund Investments

Members of the TMA Board of Trustees serve as trustees or as the board of trustees for two library funds, two student loan funds, one student and resident loan fund, the Physicians Benevolent Fund, 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 the board review quarterly reports from: TMA's equity investment manager, Luther King Capital Management; TMA's fixed income investment manager, Vaughan Nelson Investment Management, LP; and TMA's international stock fund managers, Dodge & Cox. The board establishes investment performance objectives for the investment portfolios of TMA and seven separate funds and sets policy for the mix of investment media (equities, fixed income, alternative mutual funds, and cash equivalents).

TMA's investments monitor is The Quantitative Group at Graystone Consulting, and the board's Investments Committee meets with W. Joseph Sammons, Senior Vice President, and Ronald Kern, Executive Director. The Quantitative Group is the investment monitor for TMA funds and all funds managed by TMA. The committee and the board review quarterly composite reports prepared by The Quantitative Group.

The Dec. 31, 2017, net assets of the funds managed by these investment managers were reported as follows: TMA, $31,321,180; Texas Medical Association Library, $2,664,087; Annie Lee Thompson Library Trust Fund, $3,669,691; May Owen Irrevocable Trust, $3,048,988; Dr. S. E. Thompson Scholarship Fund, $6,329,088; Physicians Benevolent Fund, $4,232,677; and Texas Medical Association Special Funds Foundation, $2,565,696.

Dec. 31, 2017, Investment Manager Performance Report

Since Dec. 31, 1993, the composite annualized performance for all equity investments has been 8.80 percent versus the equity composite index annualized rate of return of 9.32 percent. The one-year rate of return was 17.70 percent versus the equity composite index return of 20.95 percent. Equity investment allocation by manager is approximately 62 percent at Luther King Capital Management, 32 percent in iShares blended mutual funds, 4 percent in Dodge & Cox International Stock Fund, and 2 percent in the Invesco Developing Markets mutual fund.

Fixed income investment manager Vaughan Nelson Investment Management achieved a 5.42 percent annualized return versus the Barclays Aggregate annualized return of 5.55 percent for the period of June 30, 1992 through Dec. 31, 2017. The one-year rate of return was 2.76 percent versus the index return of 3.54 percent. Fixed income investment allocation by manager is approximately 58 percent at Vaughn Nelson, 23 percent in the Metropolitan West Intermediate Bond Fund, 10 percent in the JP Morgan Strategic Income Bond Fund, and 9 percent in the FPA New Income Bond Fund.

Alternative mutual fund investments have experienced an annualized return of 6.03 percent versus the HFRI Fund of Funds Composite Index annualized return of 2.60 percent for the three-year period through Dec. 31, 2017. The one-year rate of return was 10.39 versus the benchmark return of 7.74 percent. Alternatives investment allocation by manager is 100 percent in the FPA Crescent Fund.

REPORT OF BOARD OF TRUSTEES

BOT Report 7-A-18

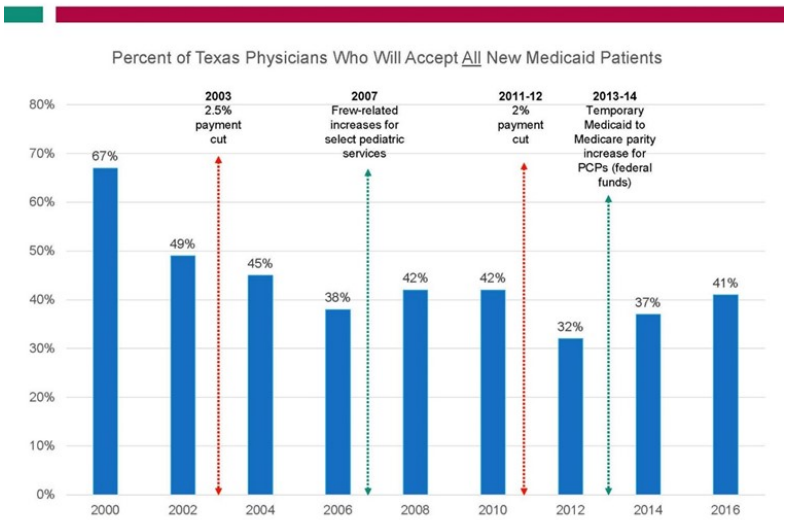
Subject: TMA/THA Physician Medicaid Rate Improvement Task Force

Presented by: David N. Henkes, MD, Chair

With the exception of a temporary two-year, federally-funded primary care physician rate increase from 2013 to 2014, physician Medicaid payments have not been substantially updated in more than a decade. In 2007, Texas increased payments for some pediatric services in order to fulfill a federal court's consent decree ruling that the state failed to comply with federal Medicaid requirements guaranteeing children access to appropriate medically necessary preventive, primary, and subspecialty care. Those increases did not apply to all payment codes, leaving out most specialties.

Further, Texas has not notably updated the Medicaid conversion factor in two decades, causing physician payments to lag well behind the cost of providing services, and Medicaid provides no annual inflation update.

However, TMA survey data indicates that Medicaid rate increases contribute to higher physician participation. As seen in the attached chart, with each measurable rate increase, the number of physicians accepting all new Medicaid patients rose too. Indeed, the number of physicians reporting they accepted all new patients rose five percentage points following the two-year federal rate update. The challenge has been to convince the Texas legislature to invest the necessary resources into the Medicaid physician network or identify alternatives.



Resolution 403 (A-17) resolved that TMA support the concept and implementation of community-based health care delivery models and collaborate with the county medical societies to advocate for the adoption of such models. Action on the resolution was tasked to the Council on Socioeconomics (CSE). At the 2017 Fall Conference, CSE heard presentations from both Harris and Dallas County Medical Society representatives on their respective activities championing physician-led, community based health care delivery models. After these presentations and upon further review of the resolution, the council felt additional expertise and resources beyond its purview would be required to effectively accomplish the resolution's goals. CSE recommended asking the board to consider the development of a TMA task force to advocate, coordinate, and facilitate work towards implementation of physician-led, community-based health care delivery models.

Concurrent to the council's work, the board, with the Texas Hospital Association, formed a joint TMA/THA Physician Medicaid Rate Improvement Task Force to explore opportunities to increase physician Medicaid payments. Members include:

TMA Members

- Doug Curran, MD, President-Elect
- Ryan Van Ramshorst, MD, Chair, Select Committee on Medicaid, CHIP, and the Uninsured (SCMCUI)
- Hanoch Patt, MD, SCMCUI
- Mary Dale Peterson, MD, President/CEO, Driscoll Children's Health Plan, SCMCUI
- John Carlo, MD, Chair, Council on Socioeconomics

THA Members

- Erin Asprec, EVP, Acute Care/Chief Transformation Officer, Memorial Hermann Health System
- Glenn Robinson, FACHE, President, Baylor Scott & White, Hillcrest Waco Region
- Ken Mitchell, MD, SVP/Chief Medical Officer, St. David's HealthCare
- Sam Bagchi, MD, System Chief Medical Officer/CMIO, Christus Health
- TBD

The task force held an inaugural meeting in February 2018 to explore joint advocacy efforts to increase physician Medicaid payments, either by using state general revenue and/or diverting dollars from the recently renewed Texas Medicaid 1115 waiver, which provides supplemental funding to offset hospitals' uncompensated care costs but no funding for physicians.

Given the overlap of issues related to Medicaid payment and development of community-led physician organizations to serve low-income patients, the TMA/THA task force also was charged with exploring opportunities to advance implementation of community-based health care delivery models as directed by Resolution 403.

Some work regarding Resolution 403 is already underway. In December, TMA hosted a meeting of the Texas Alliance for Health Care, an informal coalition of diverse health care stakeholders, including physicians, hospitals, advocacy groups, and faith-based organizations, to discuss promising physician-led health care delivery proposals, such as that proposed by the Dallas County Medical Society. Physician and county society leaders from the Dallas, Harris, and Travis county medical societies presented their respective visions for fair, accountable, physician-based health care delivery models. While the proposals vary in their degree of development, members of the Alliance, including hospital association leaders, expressed support for continued discussions about moving the idea forward. Additional meetings will be held later this year to explore possible state and federal legislative options to enact community-based health care delivery models.

The Board of Trustees subsequently directed CSE to: (a) convene an informal work group, comprised of chairs or designees from the Council on Socioeconomics, Council on Health Care Quality, Select Committee on Medicaid, and TMA PracticeEdge, as well as county medical society leaders to discuss potential policy initiatives related to implementation of physician-led, community-based health care delivery models, (b) share recommendations of the workgroup with the BOT, relevant councils and committees and the TMA/THA Physician Medicaid Rate Improvement Task Force, and (c) continue to collaborate with the Texas Alliance for Health Care to achieve the objectives of Resolution 403.

To that end, CSE, with guidance from the board, sought candidates from the above named councils, committees, and PracticeEdge to participate on the workgroup. CSE also will invite the Council on Legislation, Council on Practice Management Services, and Committee on Medical Home and Primary Care to name participants given that those entities share a mutual interest in developing policy, advocacy, and functional tools to help practices transform. CMS leadership will be drawn from Dallas, Houston,

Austin, and the Rio GrandeValley. To ensure geographic and practice size diversity on the workgroup, it will include physicians drawn from rural and urban communities as well as large and small practices. The workgroup will hold its initial meeting during TexMed 2018.

Concurrent to TMA activities, the Texas Health and Human Services Commission (HHSC) will be collaborating with key stakeholders to advance value-based payment (VBP) not only in Texas Medicaid but also within the Employee Retirement System (ERS) and Teacher Retirement System (TRS). The Texas Legislature directed HHSC, ERS, and TRS to identify opportunities to integrate VBP across all three payers. Advising the agency on VBP activities is a public-private, multi-stakeholder VBP and Quality Advisory Committee on which several TMA leaders serve.

Last December, the agency and University of Texas Dell Medical School hosted a symposium to introduce a new Texas Medicaid Value-Based Payment framework, share how other states have approached VBP within their public (and private) health care systems, distribute best practice ideas, and solicit broad stakeholder feedback on Texas initiatives. (HHSC contracted with Dell Medical School to help with stakeholder engagement on VBP.) Several hundred health policy leaders in a variety of disciplines attended the event. Attending on behalf of TMA were Carlos Cardenas, MD, President; John Carlo, MD, chair, Council on Socioeconomics; Ryan Van Ramshorst, MD, Chair, Select Committee on Medicaid, CHIP and the Uninsured; and Yasser Zeid, MD, Council on Legislation and member of the Select Committee on Medicaid SCMCUI. Numerous other TMA leaders also attended.

Key areas around which Texas Medicaid and other public payers will focus VBP strategies are maternity/newborn care, patient centered medical homes/health homes (including integrated behavioral health and screening for social determinants), telemedicine/telehealth, foundational steps to VBP for small and rural providers, and integrating medical and social services to address social determinants of health care utilization and outcomes for high-risk individuals.

Following the symposium, in February, Mark McClellan, MD, MPH, a senior policy advisor to the Dell Medical School and a former administrator for the Centers for Medicare & Medicaid Services, spoke to the VBP Committee regarding lessons learned from the symposium. Key among the challenges facing Texas will be helping solo and small physician practices adapt to the state's rapidly changing health care delivery landscape. Additionally, HHSC, in partnership with physicians and managed care organizations (MCOs), must expedite efforts to eliminate the Medicaid red tape that hinders development of alternative payment models. TMA senior staff also spoke to the HHSC VBP Committee to emphasize the challenges facing Texas physicians seeking to transform their practices, including inadequate Medicaid payments, inconsistent Medicaid fee-for-service and managed care policies and rules, ineffective and uncoordinated electronic health records, disjointed care coordination across Medicaid managed care programs, and lack of resources to respond to and manage social determinants of health.

In the near future, it is expected HHSC and Dell Medical School will be forming a provider advisory committee to assess VBP readiness and develop tools to help physicians other providers adapt.

REPORT OF BOARD OF TRUSTEES

BOT Report 8-A-18

Subject: Audit of 2016 Financial Statements and 2017-18 Operating Budgets

Presented by: David N. Henkes, MD, Chair

Audit of 2016 Financial Statements

The *Audit of 2016 Financial Statements* report was presented to the TMA Board of Trustees at its Sept. 15, 2017, meeting. Independent auditor Holtzman Partners, LLP, determined the consolidated financial statements "present fairly, in all material respects, the consolidated financial position of Texas Medical Association and Texas Medical Association Board Administered Organizations . . . in 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 TMA member.

2017 Operating Budget

For 2017, operating income was $25,679,475 and operating expenses were $26,278,704. At year-end, total actual operating income for the year exceeded the budgeted operating income by $89,135 (0.35 percent). Total actual operating expenses were over budget by $594,364 (2.31 percent), resulting in an actual net operating deficit of $599,229. This actual net operating deficit was greater than the budgeted net operating deficit by $505,229. An unaudited report on 2017 operations is attached.

The *Audit of 2017 Financial Statements* report by Holtzman Partners, LLP, will be completed and presented to the Board of Trustees at its 2018 fall meeting. The board will present the audit reports to the House of Delegates in 2018.

2018 Operating Budget

In December 2017, the Board of Trustees approved a 2018 operating budget projecting an income of $26,158,610 and expenses of $26,158,610, with a 2018 capital expenditure budget of $784,000. The operating budget will be presented to the house by Board of Trustees Chair David Henkes, MD. The board also approved direct financial support of related organizations in 2018 as follows: TEXPAC request for support totaling $349,320; TMA Alliance request for support totaling $336,920; TMA Foundation request for support totaling $115,000; and Association Management Services request for support totaling $1,173,360. Offsetting these expenses are: projected 2018 TMA special society administration fees totaling $1,172,250; corporate contributions of $50,000 to TEXPAC; and $15,000 in grant revenue received for TMA Foundation programming.

The 2018 expense budget of $26,158,610 represents an increase of $568,270 from the final 2017 expense budget. Supporting this expense budget is a projected income budget of $26,158,610. This represents an increase of $474,270 from the final 2017 income budget of $25,684,340. As a result, a break-even budget is projected for 2018.

The 2018 budgeting process included a review of all programmatic activities. TMA's relevance and value to its members were used as benchmarks for evaluating programs and determining which areas to expand or reduce. As containing expenses for approved programs becomes increasingly difficult, programmatic growth must be restrained or new sources of income identified. The 2018 Operating Budget adopted by the board is attached.

Texas Medical Association UNAUDITED
Statement of Income and Expense by Program
For the Year Ending December 31, 2017

			Operating Fund Budget Comparison			
Income	**Total Income**	**Building Fund Income**	**Actual Income**	**Budgeted Income**	**Variance**	**% Variance**
Membership Recruitment & Retention	16,195,217		16,195,217	16,125,000	70,217	0.44%
Royalty Income	2,165,640		2,165,640	2,146,500	19,140	0.89%
Rental Income	1,513,687		1,513,687	1,515,520	(1,833)	(0.12%)
Related Organizations	1,424,166		1,424,166	1,308,010	116,156	8.88%
Organizational Support Activities	1,120,819		1,120,819	961,280	159,539	16.60%
Communications	900,494		900,494	833,450	67,044	8.04%
Marketing and Member Services	831,919		831,919	1,081,470	(249,551)	(23.08%)
TexMed and Conferences	433,975		433,975	421,000	12,975	3.08%
Investment Income	476,746	86,875	389,871	270,700	119,171	44.02%
Educational Programs	277,106		277,106	534,400	(257,294)	(48.15%)
Medical Education	153,158		153,158	190,910	(37,752)	(19.77%)
Advocacy and Public Policy	141,450		141,450	106,000	35,450	33.44%
Public Health - Quality - Science	88,887		88,887	46,500	42,387	91.15%
Information Systems	22,759		22,759	19,000	3,759	19.78%
Legal	19,452		19,452	30,600	(11,148)	(36.43%)
Boards, Councils, Committees	875		875	0	875	
Total Income	25,766,350	86,875	25,679,475	25,590,340	89,135	0.35%
Expense	**Total Expense**	**Building Fund Expense**	**Actual Expense**	**Budgeted Expense**	**Variance**	**% Variance**
Organizational Support Activities	4,555,014		4,555,014	3,965,260	589,754	14.87%
Communications	2,960,182		2,960,182	3,121,050	(160,868)	(5.15%)
Public Policy	2,405,146		2,405,146	2,232,280	172,866	7.74%
Building Operations	2,187,550		2,187,550	2,282,850	(95,300)	(4.17%)
Membership Recruitment & Retention	2,118,779		2,118,779	1,939,800	178,979	9.23%
Related Organizations	2,111,008		2,111,008	2,123,230	(12,222)	(0.58%)
TexMed and Conferences	1,767,828		1,767,828	1,565,010	202,818	12.96%
Information Systems	1,715,655		1,715,655	1,655,260	60,395	3.65%
Legal	1,345,250		1,345,250	1,360,060	(14,810)	(1.09%)
Depreciation	1,079,788		1,079,788	1,062,200	17,588	1.66%
Health Policy - Regulation	1,061,633		1,061,633	1,196,990	(135,357)	(11.31%)
Public Health - Quality - Science	905,063		905,063	893,760	11,303	1.26%
Marketing and Member Services	808,789		808,789	906,840	(98,051)	(10.81%)
Boards, Councils, Committees	487,265		487,265	412,910	74,355	18.01%
Medical Education	459,213		459,213	469,440	(10,227)	(2.18%)
Educational Programs	310,541		310,541	497,400	(186,859)	(37.57%)
Total Expense	26,278,704	0	26,278,704	25,684,340	594,364	2.31%
Net Income (Loss)	(512,354)	86,875	(599,229)	(94,000)	(505,229)	
Unrealized Gain (Loss) on Investments	909,766	352,719	557,047			
Realized Investment Gain (Loss)	1,729,085	173,647	1,555,438			
Realized Gain on Sale of Fixed Assets	(4,147)	0	(4,147)			
Net Balance	2,122,350	613,241	1,509,109	(94,000)	(505,229)	

Texas Medical Association
2018 Operating Budget

	2018 Budget	2017 Budget*	Change $	Change %	% of Budget
Income					
Membership Recruitment and Retention	$ 16,550,000	$ 16,125,000	$425,000	2.6%	63.3%
Marketing and Member Services	3,606,270	3,597,970	8,300	0.2%	13.8%
Building Operations	1,556,050	1,515,520	40,530	2.7%	5.9%
Related Organization Support	1,237,250	1,308,010	(70,760)	(5.4%)	4.7%
Organization and Support Activities	835,480	700,180	135,300	19.3%	3.2%
Communications	833,050	833,450	(400)	0.0%	3.2%
Educational Seminars and Publications	534,400	534,400	0	0.0%	2.0%
Conferences	421,000	421,000	0	0.0%	1.6%
Information Technology	228,960	180,800	48,160	26.6%	0.9%
Medical Education	186,050	190,910	(4,860)	(2.5%)	0.8%
Public Health - Quality - Science	79,500	46,500	33,000	71.0%	0.3%
Advocacy and Public Policy	60,000	106,000	(46,000)	(43.4%)	0.2%
Legal	30,600	30,600	0	0.0%	0.1%
	$ 26,158,610	$ 25,590,340	$568,270	2.2%	100.0%
Expense					
Organization and Support Activities	$ 3,410,540	$ 3,357,760	$ 52,780	1.6%	13.0%
Communications	2,997,580	3,121,050	(123,470)	(4.0%)	11.5%
Membership Recruitment and Retention	2,895,130	2,584,230	310,900	12.0%	11.1%
Advocacy and Public Policy	2,348,100	2,232,280	115,820	5.2%	9.0%
Building Operations	2,230,530	2,282,850	(52,320)	(2.3%)	8.5%
Related Organization Support	1,974,600	2,123,230	(148,630)	(7.0%)	7.5%
Conferences	1,678,090	1,565,010	113,080	7.2%	6.4%
Legal	1,376,870	1,360,060	16,810	1.2%	5.3%
Marketing and Member Services	1,363,400	1,309,680	53,720	4.1%	5.2%
Information Technology	1,272,690	1,215,490	57,200	4.7%	5.0%
Health Policy - Regulation	1,078,060	1,196,990	(118,930)	(9.9%)	4.1%
Public Health - Quality - Science	953,580	893,760	59,820	6.7%	3.6%
Depreciation on Furniture and Equipment	584,800	542,700	42,100	7.8%	2.2%
Depreciation on Building	532,100	519,500	12,600	2.4%	2.0%
Educational Seminars and Publications	503,500	497,400	6,100	1.2%	2.0%
Boards, Councils and Committees	483,390	412,910	70,480	17.1%	1.8%
Medical Education	475,650	469,440	6,210	1.3%	1.8%
	$ 26,158,610	$ 25,684,340	$ 474,270	1.8%	100.0%
Net Budget Surplus	$ -	$ (94,000)	$ 94,000		

**2017 budget as approved by Board of Trustees including amendments.*

REPORT OF BOARD OF TRUSTEES

BOT Report 9-A-18

Subject: 2017-18 Board Officers and Committees

Presented by: David N. Henkes, 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 2017, the board elected David N. Henkes, MD, chair; David C. Fleeger, MD, as vice chair; and Gary W. Floyd, MD, as secretary. Richard W. Snyder, 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, Carlos J. Cardenas, MD. The board also welcomed Justin M. Bishop, MD, as the resident member, and Patrick D. Crowley as the medical student member for 2017-18.

Board committees for 2016-17 are: Investments (Dr. Floyd, chair; Michelle Berger, MD; Keith Bourgeois, MD; G. Ray Callas, MD; Douglas W. Curran, MD; Dr. Fleeger; Dr. Henkes; Dr. Snyder; and TMA Foundation liaison Craig Norman, RPh) and Educational Scholarship and Loan (Diana Fite, MD, chair; Sue Bornstein, MD; Don R. Read, MD; Dr. Villarreal; Arlo F. Weltge, MD; Dr. Bishop; Mr. Crowley; Dr. S.E. Thompson Scholarship Fund Trustee Raymond S. Greenberg, MD; Resident and Fellow Section representative Habeeb Salameh, MD; Medical Student Section representative Jordan McKinney; and TMA Alliance representatives Pam Abernathy, James P. Davis, and Rebecca Waller).

Drs. Bornstein, Fleeger and Read, and Carrie de Moor, MD, represent the board on the TMA/Texas Osteopathic Medical Association/TMF Health Quality Institute Liaison Committee. Drs. Bourgeois, Cardenas, Curran, Fleeger, and de Moor, and Susan Strate, 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; Shirley Sanders, and Catherine Scholl, MD. 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. J. J. Waller, MD, serves as the TMA Alliance representative; Brittany Rosales, MD, as the RFS representative; George Parker as the MSS representative; and Yohan Kim as the MSS alternate representative.

The TMA board also appoints the *Texas Medicine* Editorial Board. Owen E. Winsett, MD, chairs the board. Members are Chelsea I. Clinton, MD; Christopher Garrison, MD; John C. Jennings, MD; Roger Khetan, MD; Charlotte H. Smith, MD; Gary Ventolini, MD; and Alexis Wiesenthall, MD. Mi Mickey Yang, MD, serves as the RFS representative and Pranati Pillutla as the MSS representative.

REPORT OF BOARD OF TRUSTEES

BOT Report 10-A-18

Subject: Medical Student and Resident Physician Loan Funds

Presented by: David N. Henkes, 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, 2017, 58 loans totaling $232,472 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 $6,000 were disbursed from July 1 through Dec. 31, 2017.

In January 2018, the board approved allocations for the 2018-19 school year totaling $654,000, including $36,000 for residents. The loan allocations to the 12 medical schools are based on availability of funds and the history of each school's utilization.

REPORT OF BOARD OF TRUSTEES

BOT Report 11-A-18

Subject: Minority Scholarship Program

Presented by: David N. Henkes, MD, Chair

The TMA Minority Scholarship Program has given one hundred and one (101) $5,000; twenty-two (22) $10,000; and one (1) $2,500 scholarships to underrepresented minority medical students in Texas since it was established in 1998. Twelve Texas medical schools have received an award, and the rotation schedule will continue as funds are available. As of Jan. 10, 2018, the TMA Foundation has collected more than $20,500 in cash and pledges for the 2018 scholarships. Any shortfalls will be covered by 2016 donations received from two private donors: Robert J. Bayardo, MD, and Patrick Leung, MD.

This year, the program will award 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 Office of Trust Fund Administration must have received candidate applications by Feb. 24, 2018. TMA will notify scholarship recipients in April and make the presentation ceremony at TexMed 2018 on May 18 in San Antonio.

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 EXECUTIVE VICE PRESIDENT

EVP Report 1-A-18

Subject: 2017-18 Update

Presented by: Louis J. Goodman, PhD

State of the Association

2017 was a successful year for your Texas Medical Association, closing with a total of 51,532 members, a net gain of 1,674 members, and a year-over-year membership increase of 3 percent. The number of 100-percent groups increased from 240 to 251.

Highlights of 2017 accomplishments include:

- Persuaded the Centers for Medicare & Medicaid Services to drop enrollment requirements for physicians temporarily displaced due to Hurricane Harvey.
- Sent regular email news updates to more than 18,000 member and nonmember physicians in counties declared disaster areas due to Hurricane Harvey. Arranged with a third party to generate and update maps and lists of open pharmacies from Beaumont to Corpus Christi.
- Recovered more than $2 million from health plans for physicians via the Hassle Factor Log.
- Won major concessions in proposed new Medicare Access and CHIP Reauthorization Act (MACRA) requirements for physicians.
- Selected a revenue cycle management (RCM) vendor and established a memorandum of understanding to conduct pilots in physician practices for jointly delivered RCM services.
- Provided ongoing education and automated reminders to physicians about their Medicare enrollment status and how to complete revalidation so they do not lose Medicare billing privileges.
- Stopped UnitedHealthcare (UHC) plans from eliminating payment for consultations billed and implementing the Beacon Lab program for commercial UHC business.
- Advocated for the Texas Department of Insurance (TDI) to address the lack of physician participation in the Workers' Compensation designated doctor program and the increasing number of chiropractors being used to provide designated doctor exams.
- Provided more than $150,000 worth of free in-house expertise services on billing, coding, and practice operations.
- Increased practice consulting revenue by 12 percent and built practice management content in the TMA Education Center to provide 33 on-demand webinars, 24 hard-copy publications, and 54 electronic (.pdf) publications. Increased participation in live webcasts by 39 percent.
- Initiated streamlining of the Physician Health and Wellness Program. This includes evaluations of current continuing medical education (CME), review of meeting schedules and mini-conferences, and committee sunset review.
- Achieved a successful 85th Texas Legislature, with lobby, legal, policy, and communications support on nearly 1,500 bills. Legislative wins on key fronts:
  - Defeated $1 billion in proposed cuts to Medicaid.
  - Defeated nearly 30 dangerous scope of practice bills; no scope bills passed.
  - Won additional dollars for graduate medical education ($48.3 million more) and mental health ($625 million more).
  - Protected physicians' ability to balance bill by expanding the billing mediation process to all physicians and others providing out-of-network services at certain in-network facilities and to out-of-network situations for emergency care.
  - Renewed Texas Medical Board (TMB) and Texas Medical Practice Act for two years.

  - Established a statutory definition for telemedicine and clarified that the standard of care for a traditional, in-person medical setting also applies to telemedicine services.
  - Passed legislation prohibiting the state from using maintenance of certification (MOC) as a requirement for state licensure or renewal, or insurance participation — but permits health facilities to use MOC if the hospital medical staff vote it is appropriate for their own hospital.
  - Passed ban on texting while driving.
  - Passed new law empowering physicians to override health plans' step therapy protocols.
  - Won significant concessions protecting physicians' liability and professional ethics in a do-not-resuscitate bill that passed in the special session.
- Mobilized grassroots participation in the legislative process:
  - 55 TMA members testified at 94 separate legislative committee hearings.
  - 732 physicians, medical students, and alliance members from 37 county societies participated in First Tuesdays at the Capitol, making 1,180 legislative visits.
  - 2,535 members sent 5,266 emails and messages to state lawmakers through the TMA Grassroots Action Center.
- During the regular and special legislative sessions, sent 135 daily and weekly editions *of TMA Legislative News Hotline* to 10,300 subscribers and produced 23 *Hotline* video segments and seven legislative wrap-up videos.
- Conducted a TMA image campaign, Minutes that Matter, which met or exceeded all goals for reach and impressions, especially for audiences in and around the Texas Capitol.
- Received TMA Foundation (TMAF) Board approved for a near-record $576,163 for TMA's 2018 initiatives to improve the health of all Texans. This includes nearly doubling support for the TMA Ernest and Sarah Butler Awards for Excellence in Science Teaching.
- Launched "Deep Roots: Botanical Medicine From Plants to Prescriptions" in the Robert G. Mickey History of Medicine Gallery.
- Received a clean, unqualified audit opinion on all TMA organizations.
- Fulfilled five marketing contracts with outside entities that earn $400,000 annually; earned 102 percent of revenue goal for advertising and sponsorship.
- Strengthened TMA's use of social media:
  - Gained 790 new members via Facebook campaigns.
  - Twitter followers increased by 12 percent, to 21,000.
  - Facebook followers increased by 40 percent, to 5,650.
  - LinkedIn followers increased by 32 percent, to 1,250.
  - Instagram followers increased by 161 percent, to 280.
  - Conducted five Takeover Tuesdays on TMA Facebook page to show a day in the life of a Texas physician.
- TMA Knowledge Center:
  - Received 12,500 inbound calls and emails, a decline of 2 percent from 2016.
  - Increased views of online FAQs increased 538 percent, to 59,000.
- Negotiated no increase for 2018 plan year for staff health and dental insurance premiums.
- Devised plan to reduce costs (net savings of $115,000 projected for 2018) and increase timeliness of *Texas Medicine* and TMA's electronic newsletters.
- Jointly sponsored 19 external CME activities, including five with county medical societies and seven with state specialty societies.
- Began offering CME oversight and consulting services to other state medical societies.
- Provided information and technology data hosting services to 10 state medical societies, adding the Tennessee Medical Association to our list of hosted state societies.
- Upgraded 30 hosted county medical society websites to new clean and modern designs.

2018 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 2018 are:

- Overall, build TMA membership and nondues revenue to support the association's goals.
- Meet and/or exceed: dues budget of $16,550,000; membership count of 53,200; and retention goals of 95 percent.
- Achieve balanced 2018 actual vs. budget and 2018 dues income budget.
- Achieve 2018 overall advertising and sponsorship revenue goal of $989,250 and significantly increase nondues revenue through vendor sponsorships.
- Achieve successful 2018 election cycle.
- Prepare for 86th legislative session (interim charges, TMB sunset, proactive agenda).
- Produce *Healthy Vision 2025* — complete rewrite for next legislative and congressional sessions.
- Monitor and comment on the implementation of important medical-related legislation.
- Build external relationships to represent TMA effectively in advocacy before courts and the legislature, and in administrative agency rulemaking.
- Improve relationships with the governor and lieutenant governor.
- Improve relationship between legislators and local physicians
- Advocate TMA policy before the Texas Sunset Commission to improve TMB licensure and disciplinary fairness and due process.
- Increase engagement with TDI on:
  - Implementation of new mediation requirements;
  - Provider directory inaccuracies; and
  - Efficiency of TDI complaint process.
- Increase joint advocacy efforts with other state and national specialty societies to address health plan policy changes.
- Implement advocacy campaign on verifying provider directory accuracy and reporting errors to TDI and TMA.
- Successfully pilot and launch TMA Practice Management Holdings, LLC, revenue cycle management services using TMA Practice Management Holdings, LLC.
- Identify, educate about, and advocate for health delivery models that focus on health outcomes and value to all payers.
- Execute educational and advocacy opportunities to advance an evidence-based policy framework for population health policy development.
- Increase fundraising for TMAF and secure additional grants that are priorities for TMA in population health, science, and quality.
- Educate physicians and health care stakeholders about implementation and compliance issues with the Medicare Quality Payment Program.
- Advocate for adequate funding and data analysis for medical education and the physician workforce.
- Maintain and build upon strong external collaborations with local, state, and national thought leaders.
- Implement a new fee structure for TMA's CME accreditation services.
- Transition Physician Health and Wellness costs from TMA's operations to those of the Physicians Benevolent Fund.
- Broaden scope of the Physician Health and Wellness program to reach a wider audience and implement continued efficiencies to processes as needed.
- Implement a Monte Carlo plan for utilization of "invested reserves" for unbudgeted special projects.
- Launch redesigned and revamped *Texas Medicine* and the *Texas Medicine Today* personalized, digital news delivery system.
- Identify and contract with new vendor(s) for the TMA Grassroots Action Center to enhance TMA's effectiveness and members' experience.
- Increase physician participation in TMA PracticeEdge and successfully launch TMA Integrated Services, LLC.
- Increase physician participation in the 2018 TMA biannual survey, with 100-percent participation in the survey by TMA leadership, including board members and all council and committee members.

TMA Fall and Winter Conferences

In total, 447 physicians and medical students attended 2017 TMA Fall Conference; the theme of the conference was Expanding the Frontier of Texas Medicine. At the general session, Carlos Cardenas, MD, moderated a panel discussion on the Hurricane Harvey Relief Response with David Teuscher, MD, and Kirk Cole, senior advisor to the commissioner of the Texas Department of State Health Services; Thomas Kim, MD, Med2You chief medical officer, led a talk on adverse childhood events titled Adversity and Toxic Stress: What It Means to Your Patients, with Angelo Giardino, PhD, senior vice president and chief quality officer of Texas Children's Hospital, and Leslie Secrest, MD; and state Reps. Tom Oliverson, MD, and J.D. Sheffield, DO, and state Sen. Charles Schwertner, MD, joined Ray Callas, MD, in providing a 2017 legislative update.

The Dawn Duster session featured a panel discussion titled Telemedicine and Digital Health: New Texas Law, Opportunities, and Challenges moderated by Donald P. "Rocky" Wilcox, JD, with Julian Rivera, JD, Partner at Husch Blackwell, and Jared Livingston, JD, TMA assistant general counsel.

There were 535 physicians and medical students in attendance at 2018 TMA Winter Conference; the theme of the conference was Charting a Healthy Course for 2018. The program included an update on the American Medical Association by AMA Speaker of the House Susan Bailey, MD, and AMA Senior Vice President Kenneth Sharigian, PhD, followed by a panel discussion on Achieving Universal Health Care Coverage — A Conservative Road Map for How to Get There. Ryan Van Ramshorst, MD, and Avik Roy, opinion editor for *Forbes*, spoke on this topic. After the panel discussion, Carla Ortique, MD, presented an Update on Maternal Health and Safety; Dan McCoy, MD, with Dr. Cardenas, discussed Assessing the Landscape of Health Care; and Dr. Cardenas followed that discussion with another on Effective Communication: Talking to Your Patients in an Era of Fake News, along with Jason Terk, MD, and Michael Mackert, PhD, director of health communication at The University of Texas.

At the Dawn Duster session, Peter Yu, PhD, director of technology and a research scientist at Texas A&M University, gave a talk on Cyber Security: What Physicians Need to Know.

Human Resources

The association has 142 regular full-time and seven part-time equivalent positions, 7.25 of which are funded by outside sources. TMA Insurance Trust has 20 regular full-time equivalent positions.

The following people were promoted in 2017:

- Martha Danz was promoted to director, Office of the Executive Vice President.
- Christine Mojezati was promoted to director, TEXPAC.
- Kelly Walla was promoted to associate vice president/deputy general counsel, Office of the General Counsel.

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

TMA's renewal increase for the 2018 plan year was 0 percent for the standard preferred provider organization (PPO) plan, 0 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
Nicole Abbot, TMA Conference and Association Management Services
Marilyn Anderson, TMA Foundation
Casey Harrison, TMA Membership and Business Development
Lena Loomis, TMA Membership and Business Development
Clayton Stewart, TMA Advocacy
Angelica Ybarra, TMA Population Health

10 Years
Margaret Mendez, TMA Population Health
Petra Mendez, TMA Membership Operations
Trevor Weede, TMA Membership Operations
Tammy Wishard, TMA Communications

15 Years
Michael Hebert, TMA Membership Operations
Barbara Tims, TMA Communications
Sheri Williams, TMA Human Resources

20 Years
Derrick Jewell, TMA Information Technology
Leslie Jones, TMA Advocacy
William Kilsby, TMA Administrative Services
Shari Noonan, TMA Conference and Association Management Services

25 Years
Judith Julian, TMA Alliance

30 Years
Merrienne Koepsel, TMA Alliance
Pamela Hale, TMA Office of the EVP

The Physicians Foundation
In 2017, the Physicians Foundation focused on increasing physician leadership skills while raising awareness about physician wellness. This support was needed more than ever as physicians were particularly strained this year. As predicted, 2017 brought many challenges to health care as a new administration took hold, tax and health reform were pushed to the forefront, and the opioid epidemic raged on.

The Physicians Foundation continued to produce research to better understand and address the unmet needs in the evolving health care industry. In 2017, the foundation's second biennial Patient Survey gathered responses from nearly 1,800 U.S. adults to better understand how Americans are feeling when they step out of the doctor's office. This survey revealed an overwhelming majority of patients (95 percent) report satisfaction with their primary care physician, but only 11 percent of patients and 14 percent of physicians report they have all the time they need together.

The Physicians Foundation invested $5.8 million in 2017 to support grants that empower physicians in their delivery of care. In the devastating aftermath of hurricanes Harvey, Irma, and Maria, the Physicians Foundation stepped into action to provide disaster relief funding amounting to $1 million. The funding

aided thousands of affected physicians in Texas, Florida, and Puerto Rico in rebuilding practices and continuing to care for patients.

As America continues to evaluate change in health care policy, the perspectives of practicing physicians and their patients must be heard — and addressed. The Physicians Foundation will continue to be a leading voice for practicing physicians to strengthen the patient-physician relationship, support physicians in sustaining their medical practices, and help practicing physicians navigate the changing health care system. The year ahead will be vital. In 2018, the foundation will field and report its sixth biennial physician survey and use its new website for an improved grant-making process, among other core initiatives. All of these and more will ladder up to support physicians as they navigate the changing health care landscape.

Coalition of State Medical Societies

Founded by TMA in 2012, the coalition now comprises 10 state medical associations with more than 180,000 physician and medical student members. 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

Entering its third year, TMA PracticeEdge (TMAPE) again surpassed its goals for market growth as independent physicians continue to embrace the concept of value-based care. As of January 2018, the TMAPE accountable care organization (ACO) family includes 13 distinct networks across the state (compared with 10 in January 2017), and more than 550 physician participants. The number of patient lives covered in value-based contracts doubled over the past year with 202,000 lives in 12 payer contracts representing commercial plans, Medicare Advantage, and the Medicare Shared Savings Program. Exciting opportunities are in store for 2018 as TMAPE ACOs prepare for new pay-for-performance opportunities and move toward risk-based contracts for the senior population.

TMA Integrated Services

In October 2017, the TMA Board of Trustees formed a new services company, TMA Integrated Services, to support independent specialists as leaders in value-based care. The company is developing a platform to support network development, value-based care contracting and administration, and data analytics. Services are currently limited to pilots in several markets with a full launch prepared for January 2019.

REPORT OF COMMITTEE ON MEMBERSHIP

CM-M Report 1-A-18

Subject: Membership Development

Presented by: Charles E. Cowles Jr., MD, Chair

TMA Membership

The Texas Medical Association ended 2017 with 51,532 members, a net gain of 1,525 members, and a year-over-year membership increase of 3 percent. Compared to this same time last year, membership in the active dues-paying categories (including active and first year in practice) increased by 692 members or 2.2 percent. Resident members increased by 466 members or 7.4 percent. Student members also increased by 282 members or 4.9 percent.

Additionally, TMA surpassed the 2017 dues revenue budget projection. TMA collected $16.19 million on a projected dues revenue budget of $16.12 million, exceeding projections by more than $72,244. TMA's retention rate remained strong at 93 percent.

2018 Membership Recruitment and Retention Plans and Goals. TMA's Membership Development staff are committed to increasing membership and market share. TMA staff will continue in-the-field recruitment efforts including frequent and consistent local and peer-to-peer outreach efforts, assistance to county medical societies, and better targeting and messaging to various membership segments.

Key 2018 membership recruitment and retention activities:

- An aggressive in-the-field recruitment strategy.
- A focus on group practice recruitment strategies in the metro and surrounding county medical societies.
- A strong proactive plan of action for assisting and strengthening county medical societies.

TMA 2018 goals include:

- Increasing membership in the association to 53,000 members –an increase of 1,468, or 2.8 percent.
- Achieving or exceeding a dues revenue goal of $16.55 million.
- Retaining 95 percent of recruitable members.
- Increasing Ambassador activities to 85 programs. *(These are organized and consistently scheduled local activities with physicians via county medical society and other local-market activities, e.g., through hospital medical staff meetings and large groups.)*

Summary

TMA membership remains strong. The committee will continue to provide guidance in the development of membership recruitment and retention programs. Additionally, the committee will continue to help staff focus and implement recommendations from the 2016 Member Survey and accompanying research to ensure a strong and stable future for TMA.

REPORT OF BOARD OF COUNCILORS

BOC Report 1-A-18

Subject: Distinguished Service Award — Surendra K. Varma, MD

Presented by: Charles M. Perricone, MD, Chair

Acting upon a nomination by the Lubbock County Medical Society (Lubbock CMS), the Board of Councilors has selected Surendra K. Varma, MD, of Lubbock to receive the association's Distinguished Service Award. The award will be presented on Saturday, May 19, 2018, at the business session of the House of Delegates.

Dr. Varma has been a member of Lubbock CMS and the Texas Medical Association for 37 years. He received his medical degree from King George's Medical College in Lucknow, India. After graduating, he completed fellowships in pediatrics and endocrinology at Harvard Medical School before completing his residency in pediatrics at Massachusetts General Hospital.

Dr. Varma is associate dean of Graduate Medical Education and Resident Affairs at the Texas Tech University Health Sciences Center (TTUHSC). He is the Ted Hartman Endowed Chair in Medical Education and vice-chairman of Pediatrics at the TTUHSC School of Medicine.

Dr. Varma has served TMA in numerous capacities, including on the Council on Medical Education, the Council on Scientific Affairs, the Council on Health Promotion, the Committee on Child and Adolescent Health, and the Committee on Academic Physicians. He has held numerous positions on state and national specialty boards, academies, and councils. Dr. Varma has served the American Medical Association as a member of the Governing Council and Section on Medical Schools, and as a Physician Section Liaison to the AMA Council on Medical Education.

Dr. Varma currently serves on the Texas Medical Board.

Dr. Varma exemplifies exceptional and distinguished service to Lubbock CMS, TMA, and the AMA.

REPORT OF BOARD OF COUNCILORS

BOC Report 2-A-18

Subject: Opinions of the Board of Councilors

Presented by: Charles M. Perricone, MD, Chair

Pursuant to TMA Bylaw 5.217, the Board of Councilors may issue opinions on matters of medical ethics. Opinions the board adopts shall be reported to the House of Delegates.

At its 2018 Winter Conference meeting, the board adopted the following opinion on Conflicts of Interest, replacing an existing policy on the same subject.

> **CONFLICTS OF INTEREST RELATED TO HEALTH FACILITY OWNERSHIP, REFERRALS, PRESCRIPTIONS, AND ORDERS.** It is not unethical, as a general rule, for a physician to own or have a financial interest in a for-profit hospital; nursing home; or other health facility, such as a free-standing surgical center or emergency clinic, even where the physician refers patients to such facility. The Board of Councilors recognizes that many health care facilities would not exist and that many medical services would not be available to patients except for the fact that responsible physicians invested in these facilities and services, thereby rendering a valuable public service. Such actions are consistent with the Principle of Medical Ethics that physicians recognize an ethical responsibility to participate in activities contributing to an improved community. However, when the holding of such business interests is influenced more by profit motive than appropriate patient care, such actions are unethical.
>
> However, due to the potential for abuse of such arrangements, the Board of Councilors recommends that physicians be mindful of the following considerations:
>
> Resolve conflicts of interest. The prime objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Under no circumstances may the physician place his or her own financial interest above the welfare of his or her patients. For example, it would be unethical for a physician to hospitalize a patient unnecessarily or prolong or reduce a patient's stay in the health facility for the physician's financial benefit. When a conflict develops between the physician's financial interests and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit.
>
> Additionally, a physician should not be influenced in the prescribing of drugs, devices, or appliances by a direct or indirect financial interest in a pharmaceutical firm or other supplier. Whether the firm is a manufacturer, distributor, wholesaler, or repackager of the products involved is immaterial. Reputable firms rely on quality and efficacy to sell their products under competitive circumstances and do not appeal to physicians to have financial involvements with the firm in order to influence their prescribing. Thus, a physician may own or operate a pharmacy if there is no resulting exploitation of patients.
>
> Likewise, a physician should not be influenced in the ordering of tests or services by a direct or indirect financial interest in a firm that sells such tests or services.
>
> Furthermore, any remuneration or return on investment should be based on the physician's percentage of capital investment and not on utilization, or the volume or value of referrals of

patients to a particular facility. It is not unethical for a physician to recover his or her investment in such a facility and earn a reasonable rate of return.

Do not engage in fee splitting. Payment by one physician to another solely for the referral of a patient is fee splitting and is improper both for the physician making the payment and the physician receiving the payment.

Fee splitting violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral.

All referrals, prescriptions, and orders must be based on the skill and quality of the physician to whom the patient has been referred, the quality and efficacy of the drug or product prescribed, or the necessity and efficacy of the test or service ordered.

The Board of Councilors reminds physicians that fee splitting is a violation of TMA Bylaws and may subject a member to disciplinary action.

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

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

Comply with applicable law. Federal and state law prohibits incentive payments designed to induce physicians to admit patients to a hospital or other health care facility. Physicians may not lawfully or ethically accept such payments. Physicians may not ethically accept any payment, directly or indirectly, overtly or covertly, in cash or in kind, from a health care facility for services delivered by the facility.

Further, the Medical Practice Act, as interpreted by the Office of the Attorney General of Texas, may prohibit the direct division on a percentage basis of a physician's professional income with lay persons or to lay shareholders in a corporation or other business enterprise.

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

REPORT OF BOARD OF COUNCILORS

BOC Report 3-A-18

Subject: County Medical Societies

Presented by: Charles M. Perricone, MD, Chair

Bexar County Medical Society Constitution and Bylaws

The Board of Councilors approved amendments to the Bexar County Medical Society's constitution and bylaws.

Lubbock-Crosby-Garza County Medical Society Name Change, Constitution and Bylaws

The Board of Councilors approved the request from Lubbock-Crosby-Garza County Medical Society to change its name to Lubbock County Medical Society. The Board of Councilors also approved amendments to the constitution and bylaws reflecting this name change.

Travis County Medical Society Constitution and Bylaws

The Board of Councilors approved amendments to the Travis County Medical Society's constitution and bylaws.

REPORT OF COMMITTEE ON PHYSICIAN HEALTH AND WELLNESS

CM-PHW Report 1-A-18

Subject: 2018 Goals; PHR Assistance Fund; Drug Screen Program

Presented by: Cheryl L. Hurd, MD, Chair

2018 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 physician health and wellness (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

The Physician Health and Rehabilitation (PHR) Assistance Fund was established in 1983. The purpose of the fund is to provide financial assistance to physicians who cannot afford treatment for depression, substance use disorders, or other potentially impairing conditions. Financial assistance also is available for short-term living expenses while a physician receives treatment.

During 2017, the PHR Assistance Fund received $10,000 in donations. The 2018 campaign benefiting the fund, Have a Heart for Physicians, will occur during May. In February, the PHW Committee will mail 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. New promotional opportunities for the campaign include reaching out to physician monitors and district coordinators, use of welcome slides at meetings, and *Texas Medicine Today* with links to a story and video on the TMA website in order to create searchable content on the internet.

For the past five years, the PHR Assistance Fund has issued loans to an average of two physicians per year, with an average loan of $3,900.

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.

REPORT OF COMMITTEE ON PHYSICIAN HEALTH AND WELLNESS

CM-PHW Report 2-A-18

Subject: Continuing Medical Education Programs

Presented by: Cheryl L. Hurd, MD, Chair

Live Presentation, Internet, and Home Study Courses

The Physician Health and Wellness (PHW) Committee offers 30 continuing medical education (CME) 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. Twenty-two courses are also available on the internet. During 2017, team members gave 61 presentations to 3,459 participants. Another 1,647 physicians completed the courses by internet. Forty-one physicians completed home studies. The committee decided to phase out the home study option and will offer the remaining printed home study courses at a clearance price. The courses will still be available online.

During 2017, the committee reviewed 15 existing courses. Thirteen courses are scheduled for review during 2018.

Wellness. It Does A Doctor Good. (PHW Training Session and Retreat) (2018)

The committee held a training session and retreat on Feb. 23 in Montgomery. The program was designed for physicians of all specialties, including members and potential new members on the committee's education teams; hospital leadership. Physicians attending the session learned how creating their own positive environments can improve performance and patient outcomes and help recapture their passion for medicine. Strategies presented included: (a) use of coaching psychology to improve the patient physician relationship; (b) use of yoga to reduce stress and improve health; (c) enhanced communication skills for better presentations; (d) use of resilience to promote work/life balance; and (e) applying wellness concepts for better self-care.

TexMed 2018

Details for CME at TexMed are being finalized but will focus on PHW, including a presentation of the course Achieving Happiness. The amount of CME and Ethics credits offered is to be determined.

PHW Fall Conference 2018

The PHW Fall Conference will be held on Saturday, September 29, after TMA Fall Conference adjourns. Details are being finalized, but the focus will be on physician stress and burnout and physician suicide. This will take place from noon to 5:15 pm, including one hour for lunch. The conference will include presentations from PHW Committee members and a keynote speaker (still to be determined), and will offer 4 *AMA PRA Category 1*™ credits and 4 ethics credits.

REPORT OF COMMITTEE ON PHYSICIAN HEALTH AND WELLNESS

CM-PHW Report 3-A-18

Subject: Treatment Facilities; Medical Student and Resident Activities

Presented by: Cheryl L. Hurd, MD, Chair

Treatment Facilities

The committee completed review of the treatment facilities surveyed in November 2017 to ascertain whether they meet committee-established criteria. A list of facilities meeting the criteria will be distributed to Physician Health and Wellness (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 2017, the committee reviewed and updated two medical student courses: Boundaries: What You Need to Know, and Challenging Patient Encounters. 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.

REPORT OF TEXAS DELEGATION TO THE AMA

TEXDEL Report 1-A-18

Subject: AMA House of Delegates Meetings in 2017

Presented by: David N. Henkes, MD, Chair

2017 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 10-14, 2017, in Chicago. The AMA house elected the two candidates Texas ran for AMA office and adopted several Texas policy statements.

All three of the policy proposals Texas took to the meeting were approved by the AMA House of Delegates. One directs AMA to push the Centers for Medicare & Medicaid Services (CMS) for flexibility beyond the current maximum of five years on the graduate medical education (GME) cap-setting deadline for new residency programs. This will especially help GME programs in medically underserved areas.

The second tells AMA to ask that CMS create an exception to the current regulation that says physicians can bill locum tenens for no more than 60 days. The exception to the 60-day limit would apply to physicians facing illnesses, family emergencies, or prolonged absences after childbirth.

The third Texas resolution called on AMA to adopt minimum federal standards for the sale of health insurance across state lines, another policy proposal under consideration in Congress. Rather than put off action on this politically hot issue, the house voted for a specific set of standards. The adopted policy states that any legislation allowing cross-border insurance sales should not weaken any state's protections on key issues such as network adequacy, contracting, prompt payment, and appeals.

<u>No Medicaid Funding Caps</u>

The House of Delegates adopted a simple statement that AMA opposes caps on federal Medicaid funding, a key financing provision in congressional Republicans' plan to repeal and replace the Affordable Care Act.

<u>Maintenance of Certification</u>

Physicians expressed their continued outrage at mandatory maintenance of certification (MOC) requirements and at the national boards that administer the certification programs. The AMA House of Delegates unanimously adopted a report which calls for: (1) recognition that "high quality continuing medical education appropriate to that physician's medical practice" is the best approach to lifelong learning for physicians; (2) elimination of high-stakes examinations in MOC; (3) ABMS to continue to display publicly a physician's initial board certification status even if the physician chooses not to participate in MOC; (4) further studies of how AMA can help state medical societies lobby for laws such as one recently passed by the Texas Legislature that bar state licensing boards, hospitals, and insurance companies from requiring MOC; and (5) further study of a proposal to oppose ABMS direct-to-consumer marketing that links MOC participation with improved health outcomes.

<u>Other Action Taken</u>

Delegates addressed various other economic, legislative, and organizational topics. The house:

- revamped proposed policy on out-of network billing to ensure it doesn't contradict recent gains physicians won in the 2017 Texas Legislature;

- said CMS should revise and simplify the Medicare and CHIP Reauthorization Act (MACRA) rules to ease the regulatory burden on physicians;
- voted to strengthen AMA policy against sugar-sweetened beverages and to back state medical societies who are pushing state legislators to tax those drinks;
- said AMA will support "the movement toward a unified and standardized residency application and match system for all non-military residencies";
- adopted policy that encourages "state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine";
- said AMA should work for continued improvements to the Veterans Choice Program and better sharing of veterans' medical records among physicians in and out of the Veterans Administration;
- called for opposing laws that would deny entry or reentry to the United States of international medical students and international medical graduates who are in the country legally;
- adopted several resolutions advocating for better health care services for families held in immigration detention centers;
- installed David O. Barbe, MD, a family physician from Mountain Grove, MO, as AMA president; and
- elected Barbara L. McAneny, MD, an oncologist from Albuquerque, NM, as AMA president-elect.

2017 Interim Meeting

About 100 Texas physicians and medical students representing the TMA, various sections, and national specialty societies took part in the Nov. 11–14 interim meeting in Honolulu. Former TMA President Sue Bailey, MD, of Fort Worth, presided over her fifth session as speaker of the house. The sole resolution TMA took to Hawaii won unanimous approval.

Texans Share Lessons of Hurricane Harvey

A panel of Texas leaders participated in a special forum on disaster medicine. From staffing shelters, to providing "mental health first aid," to helping physicians rebuild flooded practices, organized medicine was a critical piece of the response to Hurricane Harvey. Lessons learned from hurricanes Katrina, Rita, Ike and others ensured that the Texas Gulf Coast was better prepared and in a better position to respond to the storm and the flooding it caused. Texas leaders participating in the forum included: Carlos Cardenas, MD, Edinburg, TMA President; Russ Kridel, MD, Houston, member of the AMA Board of Trustees; Texas Delegation members Ken Mattox, MD, Houston; Ray Callas, MD, Beaumont; Les Secrest, MD, Dallas; Diana Fite, MD, Houston; and John Carlo, MD, Dallas; and Greg Bernica, Chief Executive Officer, Harris County Medical Society, Houston.

Patient Safety Protections and Scope of Practice

The AMA house adopted resolutions to help protect patient safety and prevent inappropriate independent practice by nonphysician practitioners. The latest threats include the APRN (Advanced Practice Registered Nurses) Multistate Compact, the "doctor of medical science" degree pushed by physician assistants in some states, and the broad medical screening tests offered by nonphysician vendors. A multispecialty and multistate coalition — including Texas — pushed AMA to adopt a resolution calling for a physician workgroup to create a "consistent national strategy," a public relations plan, and legislative language to oppose the nationwide drive for nonphysicians' independent practice. The APRN Compact, which three states already have adopted, would allow APRNs to practice without physician supervision or oversight. Medicine so far has been able to stop all attempts to pass "doctor of medical science" legislation.

The house also endorsed a six-part policy on nonphysician screening tests to protect patients and to ensure adequate follow-up, including the adoption of an amendment that would require screening-test vendors to send copies of results to the patient's primary care physician.

Modifier 25

The house reacted strongly to news that some commercial health insurance companies are reducing or disallowing payments for claims with modifier 25, which physicians use when a patient receives evaluation and management (E&M) services and a procedure on the same day. Delegates directed AMA to use "any legal means possible" to ensure that health plans pay both fees at the full rate when physicians use modifier 25 appropriately.

Physician Burnout

To address growing rates of physician burnout — and its associated impact on patient care — several medical groups asked AMA to help health systems and medical societies develop programs and services to help physicians cope. Others argued that AMA should focus instead on correcting the root causes — such as government overregulation, check-the-box demands from electronic health records, and insurer and hospital meddling in patient care. Delegates referred the matter to the AMA Board of Trustees, which promised "an aggressive and comprehensive response in an expedited manner."

Other Action Taken

Delegates addressed various other economic, legislative, public health, and organizational topics. The house:

- Adopted a resolution originally written by the TMA Medical Student Section to oppose legislation or administrative actions that hurt access to federal child nutrition programs.
- Continued the push to hold national certifying boards' feet to the fire by stating that fees for MOC should reflect fairly the cost of developing and administering the tests.
- Adopted new policies to encourage routine depression screening in pregnant and postpartum women, and directed AMA to advocate for legislation to establish maternal mortality review committees to analyze deaths that occur during pregnancy or within the first year after childbirth.
- Opposed any further legalization of marijuana or cannabis for recreational or medicinal purposes, encouraged states to use cannabis tax revenue for public health purposes, and supported research to determine the medical consequences of long-term cannabis use.
- Urged the federal government to help hurricane recovery in Puerto Rico and the U.S. Virgin Islands by funding adequately their Medicaid programs.
- Asked for a recommendation, to be completed by June 2018, for a payment policy to address the site-of-service differential three-fourths the difference between what Medicare pays for services provided in hospital-owned facilities vs. independent physician practices.
- Adopted new policy providing guidance, consultation, and model legislation on peer review immunity and protection from retaliation.
- Asked the AMA Board of Trustees to tackle unconscionable drug pricing and to push for transparency from pharmacy benefit managers.
- Directed the AMA Board of Trustees to decide how to address the potential antitrust implications of a pharmacy or drug store chain buying a health insurance company.

REPORT OF TEXAS DELEGATION TO THE AMA

TEXDEL Report 2-A-18

Subject: AMA Membership, Representation, and Delegation Leadership

Presented by: David N. Henkes, MD, Chair

As of Dec. 31, 2017, American Medical Association membership in Texas totaled 16,189 compared to 16,378 during the same time last year. The year-over-year membership decrease was 1.2 percent. The student category saw a decrease of 304 student members, or 1.8 percent. The resident category increased by 213 members, or .8 percent. The physician category decreased by 98 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. Susan R. Bailey, MD, was reelected to her third one-year term as Speaker of the AMA House of Delegates, Gary W. Floyd, MD, was appointed to the AMA Council on Legislation, and John T. Carlo, MD, was elected to his first term on the AMA Council on Science and Public Health.

Texas physicians also served on the AMA Board of Trustees and six of the AMA's seven elected and appointed councils during 2017. Texans holding elected or appointed positions on AMA entities include: Monique A. Spillman, MD, PhD, Council on Ethical and Judicial Affairs; Lyle S. Thorstenson, MD, and Justin Bishop, 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 LGBT 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 and Nancy W. Dickey, MD. AMA past president Joseph T. Painter, MD, passed away in January 2017. The delegation honored him with a memorial resolution at the 2017 AMA annual meeting.

In addition to the delegates and alternate delegates representing the Texas Medical Association in the AMA House of Delegates in 2017, many other Texas physicians served in the AMA house. Delegates and alternate delegates were: Mark A. Baker, DO, American Osteopathic Association, C. Bob Basu, MD, American Society of Plastic Surgeons, Paul R. Bergstresser, MD Society for Investigative Dermatology, Brittany Bickelhaupt, MD, American Academy of Physical Medicine and Rehabilitation, 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 Academy of Orthopaedic Surgeons, Warran A. Ellsworth IV, MD, American Society for Aesthetic Plastic Surgery, Melissa J. Garretson, MD, American Academy of Pediatrics, John N. Harrington, MD, American Society of Ophthalmic Plastic and Reconstructive Surgery, Lisa Hollier, MD, American College of Obstetricians and Gynecologists, Lynne M. Kirk, MD, American College of Physicians, Robert C. Kramer, MD, American Society for Surgery of the Hand, Jonathan D. Leffert, MD, American Association of Clinical Endocrinologists, David Lichtman, MD, American Society for Surgery of the Hand, Alnoor Malick, MD, American College of Allergy, Asthma and Immunology, Sealy Massingill, MD, American College of Obstetricians and Gynecologists, Hernando J. Ortega Jr, MD, MPH, Aerospace Medical Association, Ray D. Page, DO, American Society of Clinical Oncology, Harry Papaconstantinou, MD, American Society of Colon And Rectal Surgeons, Rebecca Parker, MD, American College of Emergency Physicians, Eddie Patton, MD, American Academy of Neurology, Jeffrey Plagenhoel, MD, American Society of Anesthesiologists, Susan Pike, MD, Integrated Physician Practice Section, Carlos J. Puig, DO, International Society of Hair Restoration, Hernan M. Reyes, MD, , US Public Health Service, Camaran Roberts, MD, American College of Emergency Physicians, Daniel Shoor, MD, Aerospace Medical Association, Divya Srivastava, MD, American College of Mohs Surgery, Susan M. Strate, MD, College of American Pathologists, Claire Tibiletti, MD, International Spine Intervention Society, and Paul Wick, MD, American Psychiatric Association.

Emily Dewar and Jerome Jeevarajan served as Region 3 medical student delegates, and Hayley Rogers and Luis Seija served as Region 3 medical student alternate delegates. John Corker, MD, served as RFS sectional delegate and Samuel Mathis, MD, and Michael Metzner, MD, served as RFS sectional alternate delegates. Texas physicians and students also served on various AMA residency review committees, sections, councils, and editorial boards.

Former TMA President Robert Gunby, MD, was elected vice chair of the Organization of State Medical Association Presidents; Susan Pike, MD, was elected to the governing board of AMA's Integrated Physician Practice Section. Jerome Jeevarajan, a student at The University of Texas Southwestern Medical School in Dallas, was elected medical student delegate to the AMA House of Delegates. These Texas students were elected to AMA MSS Region 3 leadership positions: Emily Dewar, chair, McGovern Medical School at UT Health Science Center at Houston, Aaron Wolbrueck, secretary, University of North Texas Health Science Center at Fort Worth Texas College of Osteopathic Medicine, and Jason Meschin, community service chair, Texas A&M Health Science Center College of Medicine. Michael Metzner, MD, was chosen alternate delegate to the AMA house from the RFS. Texas medical students won these spots representing Region 3 in the house: Luis Seija, regional delegate, Sinan Bana, alternate delegate, Rouzbeh Kotaki,alternate delegate, and Aaron Wolbrueck, alternate delegate.

At the November meeting in Honolulu, the Texas delegation honored Clifford Moy, MD. He first joined the Texas delegation as a medical student in 1984. His tenure included a stint as chair of the AMA Council on Long Range Planning and Development. Five Texans volunteered their time to serve on reference committees at the past two meetings of the House of Delegates: Gary Floyd, MD, completed a two-year stint on the Reference Committee on AMA Finance and Governance; Ray Callas, MD, served on the Reference Committee on Legislation; Mr. Jerome Jeevarajan served on the Reference Committee on Medical Education; Arlo Weltge, MD, served on the Reference Committee on Amendments to Constitution and Bylaws, and Melissa Garretson, MD, was a member of the Reference Committee on AMA Finance and Governance.

2018 Officers

At the Texas Delegation's Jan. 26, 2018, meeting, David N. Henkes, MD, was reelected chair; Michelle A. Berger, MD, and Gary W. Floyd, MD, were elected co-vice chairs; and G. Ray Callas, MD, and Gregory M. Fuller, MD, were elected as at-large members of the Delegate Review Committee.

REPORT OF INTERNATIONAL MEDICAL GRADUATE SECTION

IMGS Report 1-A-18

Subject: Displaced and Refugee Physicians in Texas and Potential TMA Outreach (Resolution 105-A-17)

Presented by: Sejal S. Mehta, MD, Chair

Resolution 105, TMA Outreach to Displaced and Refugee Physicians, introduced by Harris County Medical Society, was adopted at TexMed A-17. The resolution directs TMA to conduct a study on: (1) the current number of displaced and refugee physicians in Texas; (2) the role TMA might play in supporting these physicians and connecting them with Texas colleagues, and impact this could have on them; and (3) the potential impact these individuals, as future TMA members, might have on the organization, with a report back to the house. Further, it asks that if the study indicates benefit to TMA regarding residents of Texas who are displaced and refugee physicians, TMA consider moving this matter forward to the American Medical Association.

Efforts to Identify Displaced and Refugee Physicians in Texas

The TMA International Medical Graduate Section researched sources or mechanisms for determining the number of displaced and refugee physicians in Texas; however, this effort were not successful. Various news sources report that Texas leads the nation in the number of refugees recently resettled into the state. Data from the Bureau of Refugees, Population, and Migration in the U.S. Department of State reported a total of 41,647 foreign nationals resettled in Texas during 2010-15. This number undoubtedly includes physicians, but how many and where they are located is unknown.

Resettlement services are available to individuals who are refugees in the United States through the U.S. Department of Health and Human Services' Office of Refugee Resettlement. This office provides specific assistance in securing employment, including recertification and recredentialing of refugee professionals. Due to privacy and security concerns, it is not possible to obtain a listing of refugees in Texas who have self-identified as physicians through this office.

Recognizing the large number of immigrants in Houston, the IMG Section made additional efforts to obtain an estimate of displaced and refugee physicians in the Houston area. However, neither Harris County Medical Society nor its Council of International and Affiliated Medical Societies has access to this information. Upon contacting individual physicians who resettled in Houston as refugees in the past, the section found they were able to identify only a small number of current refugees. In the end, it was not possible to determine a total number or to locate a reliable source for these data.

It is known that some refugee and displaced physicians are able to secure Educational Commission for Foreign Medical Graduates (ECFMG) certification, gain admission to residency training positions, and ultimately become licensed and enter medical practice in the state. There are an estimated 16,000 international medical graduates in Texas with an active Texas medical license. Approximately 18 percent of TMA members are IMGs; however, there is no way to determine how many originally located to Texas as refugees.

Potential Role of TMA to Provide Outreach and Support to Displaced and Refugee Physicians

While it is not possible to make direct contact with displaced and refugee physicians, there is the potential for TMA to provide outreach. The section suggests posting information on the TMA website that invites displaced and refugee physicians to make contact with members of the TMA IMG Section Governing

Council. Contact information for council members is readily available on the TMA website, and a special invitation can be added to the site. TMA's online search tools also can be enhanced to better direct users to the appropriate information. Members of the IMG Section will voluntarily serve as mentors and as resources for refugee physicians who need assistance in navigating the systems and processes necessary to qualify for active medical practice in the United States. Section members also will provide support and assistance in integrating refugee physicians into American society and within the Family of Medicine, particularly for those who are eligible for TMA membership.

In addition, TMA can reach out to the various Office of Refugee Resettlement state refugee coordinators across the state to provide flyers or other information for distribution to refugee physicians served through the office's programs.

As mentioned above, the Office of Refugee Resettlement provides guidance to refugee physicians on recertification and recredentialing, which includes an explanation of the pathway for being eligible to practice medicine in the United States. The website for this federal program provides information on:

- How to obtain an ECFMG certificate,
- National Resident Matching Program and the process for participating in the annual match to secure a training position, and
- Medical licensing requirements for each state

Because this information is readily available to these physicians, there is no need for TMA to create a new resource of this type.

Potential Impact of Refugee Physicians in Texas on TMA Membership

It is assumed that the authors of Resolution 105-A-17 intended for the IMG Section to assess on how many refugee physicians ultimately may be eligible to meet TMA membership requirements. Without knowing how many refugee physicians in Texas will be successful in (1) obtaining an ECFMG certificate, (2) securing a residency position, (3) passing the U.S. Medical Licensing Examination, and (4) meeting the state's medical licensing requirements (and when), it is not possible to predict the potential impact of refugee physicians on TMA membership. It is anticipated, however, that only a portion of refugee physicians will be able to meet all of these requirements.

In 2017, 47.6 percent of non-U.S. citizen graduates of international medical schools did not match to a residency position. The current shortage of first-year residency positions has increased the competition for all applicants to residency programs. For all of these reasons, it is assumed that refugees would have only a slight potential impact on TMA membership in the years to come.

Summary

Without the ability to obtain contact information for displaced and refugee physicians, TMA is limited in its ability to provide direct support and guidance. TMA's IMG Section will further investigate possibilities for promoting the availability of section members willing to serve as mentors for displaced and refugee physicians in need of guidance and direction in navigating the systems for becoming eligible to practice medicine in the United States. Members of the IMG Section also will voluntarily seek to assist displaced and refugee physicians with integration in American society and within the Family of Medicine, particularly for those who are eligible for TMA membership. Given the challenges of successfully navigating the residency training and medical licensing processes, displaced and refugee physicians are projected to have only a slight potential impact on TMA membership in the years to come.

REPORT OF COUNCIL ON HEALTH CARE QUALITY

CHCQ Report 1-A-18

Subject: Quality Update

Presented by: Ghassan F. Salman, MD, Chair

The TMA Council on Health Care Quality oversees and supports the direction for TMA activities on health care quality including policy, advocacy, and education on quality improvement, patient safety, performance measurement, and clinical effectiveness. Austin physician Ghassan F. Salman, MD, MBA, MPH, FACP, is the council chair. The council has been active in numerous activities, summarized below.

Background

Since the Medicare Access and CHIP Reauthorization Act (MACRA) was enacted in 2015, the council has an ongoing focus on physician advocacy and education on the provisions of the law that affect practicing physicians in the areas of health care quality and performance measurement. MACRA changes the way physicians are paid in Medicare and requires the Centers for Medicare & Medicaid Services (CMS) to implement two value-based payment tracks. These center around individual physician and group performance measurement on quality, technology use, and cost metrics, as well as practice improvement activities intended to improve quality outcomes and reduce Medicare costs. The first track involves participation in advanced alternative payment models (APMs) that include financial risk but offer 5-percent lump-sum incentive payments in addition to APM-specific rewards. The second track is the Merit-Based Incentive Payment System (MIPS), a fee-for-service option with payments adjustments (bonuses and penalties) determined by annual performance scores and applied on a per-claim basis.

To implement the two tracks, CMS created the Quality Payment Program (QPP) for eligible physicians and clinicians, under which physicians either participate in an advanced APM or default to the MIPS track. Participation in the QPP requires annual quality reporting to CMS through various data collection and submission methods. Data submitted for a given performance year affects Medicare Physician Fee Schedule payments two years later. Eligible physicians and clinicians who are required to participate in the QPP, but choose not to, face automatic payment penalties (pay cuts) on a per-claim basis that stand for an entire calendar year. Pay cuts start at 4 percent in 2019, increase gradually, and cap at 9 percent in 2022 and beyond.

The first QPP performance year began in 2017, the second on Jan. 1. Under MACRA, APM incentive payments and MIPS payment adjustments will begin in 2019 based on 2017 performance, payment in 2020 will based on 2018 performance, and so on.

Physician Advocacy

Under the direction of the council, and as part of TMA's ongoing advocacy and policy analysis, staff from the TMA MACRA Task Force analyzed the 2018 QPP proposed rule last year and submitted a comment letter to CMS with more than 50 recommendations to improve the program and ease administrative and cost burdens for physician practices. To amplify some of our recommendations, TMA worked closely with the Physicians Advocacy Institute (PAI) and Healthsperien, a Washington, D.C.-based health care consulting firm, to compose a separate comment letter to CMS.

In response to Hurricane Harvey, TMA also submitted a letter last year to David D. Teuscher, MD, the director of the U.S. Department of Health and Human Services (HHS) region that includes Texas. Due to the widespread disruption in health care delivery caused by the hurricane, TMA urged HHS and CMS to

provide Texas physicians regulatory relief from 2017 data submission requirements and 2019 payment penalties.

The 2018 QPP final rule, which outlines new and revised policies for the second year and future years, was issued by CMS in November and took effect on Jan. 1. TMA's physician advocacy and recommendations resulted in several favorable changes to the QPP. Major policy changes for the 2018 QPP performance year are:

- **A new policy for physicians affected by Hurricane Harvey.** The policy provides Texas physicians who practice in counties designated as disaster areas due to Hurricane Harvey the option to be exempt from the 2017 QPP and protections from a 4-percent Medicare penalty in 2019. TMA estimates the policy could provide relief to 27,000 physicians who accept Medicare and practice in one of the 53 Texas counties affected by the hurricane. In addition, CMS issued a separate hurricane-related policy for APMs in affected counties.
- **More physician exemptions.** An estimated 63 percent of physicians and other eligible clinicians who bill Medicare are exempt from MIPS this year because of a considerable increase to the low-volume threshold for the 2018 QPP performance year. The new threshold is now $90,000 or less in Medicare Part B allowed charges, or 200 or fewer Medicare Part B beneficiaries — this is up from $30,000 or 100 in 2017.
- **A low MIPS composite performance threshold.** The overall performance score necessary to avoid a MIPS penalty was increased only slightly. The new threshold is 15 points, up from three in 2017. This means physicians who score more than 15 of the possible 100 points in 2018 will avoid a 2020 MIPS payment penalty and be eligible for an incentive payment based on a sliding scale.
- **Continued EHR flexibilities.** Physicians still can use the 2014 or 2015 electronic health record (EHR) edition or a combination to meet requirements for the MIPS Advancing Care Information category. In addition, because the MIPS composite performance threshold was set at 15 points, physicians without an EHR in their practice still can avoid a penalty by submitting data on quality measures and/or improvement activities using other reporting methods such as through claims, registry, or attestation.
- **New bonus points.** In 2018, CMS will add up to five bonus points to the MIPS final score for physicians who treat complex patients, and an additional five bonus points to the MIPS final score for physicians who are in solo or small group practices.

Education, Resources, and Services

Due to the complexity of the program and annual changes that occur as a result of federal rulemaking, developing physician education and resources to help physicians learn about and stay abreast of program requirements is an ongoing priority of the council. Under the direction of the council, staff from the TMA MACRA Task Force continue to participate in work groups facilitated by PAI and Healthsperien. Activities include updating and producing new educational material and resources for the 2018 QPP performance year that will help physicians and groups succeed in the program and avoid Medicare payment penalties.

In addition to work group activities, TMA continues to offer a comprehensive array of education and resources to help physicians learn about and navigate the QPP. Information on education, resources, and services is published on the TMA MACRA Resource Center, including: where to get MACRA continuing medical education (CME) credits at no or low cost, information about TMA's MACRA readiness assessment and customized on-site assistance by TMA Practice Consulting, free access to PAI's MACRA QPP Resource Center and physician education initiative developed in part with TMA input, free QPP education and technical assistance by the TMF Health Quality Institute, a list of MACRA resource centers by national specialty societies, a list of federally-funded initiatives that offer education and technical

assistance to help physicians transition to the QPP at no or low cost; and TMA PracticeEdge services for physician-led accountable care organizations/APMs.

Lastly, the council will provide physician education on MACRA and the QPP during its annual quality track at TexMed 2018 and offer CME credits with ethics. All QPP education offerings, clinical tools, resources, and technical assistance are promoted routinely via TMA communication channels.

TMF Health Quality Institute

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

Specific to MACRA and the QPP, TMF works with physicians and clinicians to help them transition to MIPS and successfully advance through the program's performance categories by providing technical assistance, education, outreach, and distribution of learning modules at no cost. At the council's urging, TMA continues to collaborate with and promote services provided by TMF, connecting members to free assistance that helps them improve patient and quality outcomes, as well as navigate Medicare requirements to avoid payment penalties and maximize value-based payments. In addition, council member Luis M. Benavides, MD, and council consultant Ronald S. Walters, MD, MBA, MHA, serve on the TMF Board of Trustees, and council member Robert B. Morrow, MD, is the immediate past chair of the TMF Board.

TMF Physician Practice Quality Improvement Award Program

TMF established the Physician Practice Quality Improvement Award Program in 2012, and it has since expanded beyond Texas to include practices in Arkansas, Missouri, Oklahoma, and Puerto Rico. The program is cosponsored by TMA, the Texas Osteopathic Medical Association, and others. The award program's purpose is to recognize physician practices for their dedication and commitment to providing high-quality patient care and improving outcomes. TMA and the council have been involved in the award criteria, program marketing, and promotion through TMA communication channels and will continue to promote the award program.

TexMed 2018 Quality Activities and Quality Track

Through generous sponsorship from TMF, the council will host three quality activities at TexMed 2018: quality quick tips (mini-presentations), a one-hour presentation on quality, and a four-hour quality track with CME credits and ethics. Dr. Salman will chair the quality track, and Russell Kohl, MD, chief medical officer for TMF, will speak at all three activities. Presentation topics will focus on health care quality in an evolving health care landscape; case studies and best practices from physicians who have transitioned to innovative care delivery models; clinical strategies for implementing an effective population health management program to improve patient and population health outcomes; and MACRA and the QPP, with an interactive session to solicit feedback on physician education and resource needs.

UTHealth School of Public Health (UTSPH)

Council members Lisa L. Ehrlich, MD, and Jeffrey B. Kahn, MD, participate in the physician work group by UTSPH to provide physician input and guidance for its Transparency and Healthcare in Texas think tank. CMS approved UTSPH's establishing a Qualified Entity to research claims data by Medicare and other payers to evaluate physician performance and regional variations in Texas. Members update the council of their progress and solicit input as needed.

TMA Publications on Health Care Quality

Council members regularly contribute to articles in *Texas Medicine* on health care quality and relevant topics discussed at its meetings. In 2017, several council members were interviewed on a variety of topics and provided comments for articles on the following subjects: TMF's new CMS grant aimed to help solo physicians and small practices succeed in the QPP, proposal process for physician-focused payment models under MACRA, barriers to quality of care as a result of the peer-to-peer review process, the independent review organization process to overturn insurers' coverage denials, TMA's work with the PAI to launch a new MACRA QPP resource center and comprehensive physician education initiative, and the CMS Qualified Entity by UTSPH.

REPORT OF COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-18

Subject: Addressing Physician Mental Health Status Disclosures (Referred Resolution 111-A-17)

Presented by: Steven R. Hays, MD, Chair

Resolution 111-A-17, Addressing Physician Mental Health Status Disclosures (Medical Student Section) asked for new policies that: (1) TMA support the exclusion of questions regarding mental illness in the Texas Medical Board licensure process, specifically excluding questions related to major depressive disorder diagnoses; (2) 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 (3) 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.

This resolution was referred to the Council on Medical Education. In lieu of supporting the adoption of Resolution 111-A-17, the council is providing a report on longstanding collaboration with the Texas Medical Board to modify its reporting requirements on mental health diagnoses. This work was done to mitigate the potential chilling effects these requirements may have on the willingness of a physician, resident, or medical student to seek mental health services when needed.

Texas Medical Board Behavioral Health Reporting Requirements

The council shares the Medical Student Section'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 this type the board collects should be *only* information necessary for the board to fulfill its mission of protecting the public.

Any loss of a member of the medical community as a result of suicide is a tragic loss, and the rate of suicide among physicians 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 also is important to sustain the emerging emphasis on physician health and wellness. At the same time, the council recognizes this all must be balanced with the Texas Medical Board's duty to protect the public.

Anecdotal information provided to the council indicates 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 out of concern for the potential impact on their licensure status or future eligibility. 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 be focused on the impact on a physician's professional competency or impairment. In the case of residents, reporting should be limited to the inability to learn and perform patient care duties. It also is 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 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 effectively reduced or ameliorated the condition, as noted in the following three questions extracted from 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 positive outcome of the council's collaboration with the board is annual visits by board staff to medical schools for the purposes of strengthening relations with medical students. These visits are to inform students of the board's reporting requirements, explain how the board uses the information it collects, and promote awareness of the services available through the Texas Physician Health Program.

Continued Monitoring

The council will continue to monitor and collaborate with the board on physician and resident reporting requirements.

REPORT OF COMMITTEE ON CONTINUING EDUCATION

CM-CE Report 1-A-18

Subject: TMA CME Program Update

Presented by: Aurelio Matamoros, MD, Chair

Update on CME Providers in TMA's Intrastate Accreditation Program

Upon recommendations from the Subcommittee on Accreditation, the Committee on Continuing Education made eight accreditation decisions in 2017 regarding TMA's accredited organizations. TMA's current roster of continuing medical education (CME)-accredited organizations lists 54 organizations. The breakdown for type of organization is as follows: 42 hospitals or hospital systems; one physician group; three state specialty societies; one state agency; two regional health education centers; one university student health center; one quality improvement organization; one hospice; one regional medical staff organization for emergency services; and one county medical examiner's office.

2017 Texas CME Conference

TMA offers an annual two-day conference for physicians and staff who plan and implement CME activities. The program provides updates on CME issues, trains CME providers to meet accreditation requirements, and provides networking opportunities for CME providers. The 2017 Texas CME Conference was held June 21-23 at the Westin Houston, Memorial City, and 120 CME professionals attended. The conference focused on taking CME to the next level and preparing CME professionals for the future. Graham McMahon, MD, MMSc, of the Accreditation Council for CME (ACCME) presented the Mark Gregg Memorial Distinguished Lecture on Evolution, Alignment, and Innovation in CME. Other topics were CME for maintenance of certification (MOC), using commendation criteria as educational strategy, quality improvement, growing an online CE program with limited resources, and the basics of CME for newcomers.

CME Providers Can Help Clinicians Earn CMS Performance Incentives

In its final rule for the second year of the Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Centers for Medicare & Medicaid Services (CMS) added accredited CME as an improvement activity. This and other changes to the QPP took effect on Jan. 1, 2018.

The final rule gives accredited providers in the ACCME system the opportunity to help clinicians meet CMS expectations for engaging in quality and performance improvement activities, whereby the clinicians can avoid financial penalties and earn financial incentives. The new rule provides flexibility and freedom for educators to engage with clinicians in improvement activities that are meaningful for those learners. The rule outlines a process that can be used across specialties and practice types, can apply to a broad range of content areas, and uses a range of outcome measures. The inclusion of accredited CME reflects recommendations from ACCME and others that CMS develop a process that allows accredited providers flexibility and permission to meet clinician needs.

To meet the criteria for improvement activities in the Merit-Based Incentive Payment System (MIPS) of QPP, accredited CME providers need to implement activities that:

- Address a quality or safety gap supported by a needs assessment or problem analysis, or support the completion of such a needs assessment as part of the activity,
- Have specific, measurable aim(s) for improvement,

- Include interventions intended to result in improvement,
- Include collection and analysis of performance data to assess the impact of the interventions, and
- Define meaningful clinician participation in the activity, describe the mechanism for identifying clinicians who meet the requirements, and provide participant completion information.

MIPS criteria align with the American Board of Internal Medicine (ABIM) Practice Assessment MOC requirements. This offers another opportunity for CME providers to ease the burden on clinicians by delivering activities that meet multiple expectations. Providers can offer activities that enable clinicians to earn CME credits and ABIM Practice Assessment MOC points, which also can count for MIPS.

REPORT OF COMMITTEE ON PHYSICIAN DISTRIBUTION AND HEALTH CARE ACCESS

CM-PDHCA Report 1-A-18

Subject: Annual Physician Workforce Update

Presented by: Marco Uribe, MD, Chair

The Committee on Physician Distribution and Health Care Access is charged with monitoring and reporting on the status of the state's physician workforce (Texas Medical Association Policy 185.001 Physician Workforce Texas). Following is summary of the committee's latest assessments and findings.

Physician Workforce Trends

To assess the latest trends for the state's physician workforce, the committee obtained physician supply data for 2017 from the Health Professions Resource Center at the Texas Department of Health Services. The committee added these data to its historical workforce files to examine shifts in historical trends as well as changes from the previous year. The committee learned:

- All pathways into the state's physician workforce are continuing to grow at historically high levels:
  - Medical school enrollments,
  - Residents in training, and
  - Newly licensed physicians.
- The physician workforce has expanded at a steady annual rate of 3 percent to 5 percent over the past decade.
- Three of four newly licensed physicians in 2017 were graduates of medical schools outside of Texas: 46 percent were graduates of other U.S. states, 29 percent were from schools outside of the United States, and 26 percent were Texas graduates.
- The physician workforce expanded at more than double the rate of the state's population over the past decade. This is significant given the growth in population and is critically important for improving access to medical care for Texans.
- One-third of physicians are female, compared with one-half for the Texas population.
- The mean age for Texas physicians is 50.8, and median is 49.
- The largest age cohort is ages 41-45 (15 percent of Texas physicians, or 7,782).
- 14 percent (7,333) are 65-plus and may be nearing retirement.
- Family medicine is the largest specialty in the state (8,378).
- Texas has better ratios of population-per-physician than U.S. totals for only two of 41 specialties:
  - Interventional cardiology (Texas' ratio is 107.8 percent of the U.S. ratio), and
  - Neonatal-perinatal medicine (103 percent of U.S ratio).
- Texas has lowest ratios of population-per-physician compared with U.S. ratios for:
  - Pulmonary disease (58.6 percent of U.S. ratio), and
  - Psychiatry (60.5 percent of U.S. ratio).
- Three new medical schools opened in the state in the past two years, lifting the total number to 12 and adding 265 students to the state's composite class-size, for a state total of 2,050.
- Three more medical schools are in development through 2020. Should the three schools receive approval from the state as well as national accreditation bodies:
  - The total number of Texas medical schools will rise to 15.
  - Composite class-size will expand to 2,306 in 2020. This will place additional pressures on clinical training sites for medical students in the state, which are already stretched.
  - The number of medical graduates is projected to have a net increase of 570 from 2017 to 2024. This level of increase will result in additional strain on residency program capacity.

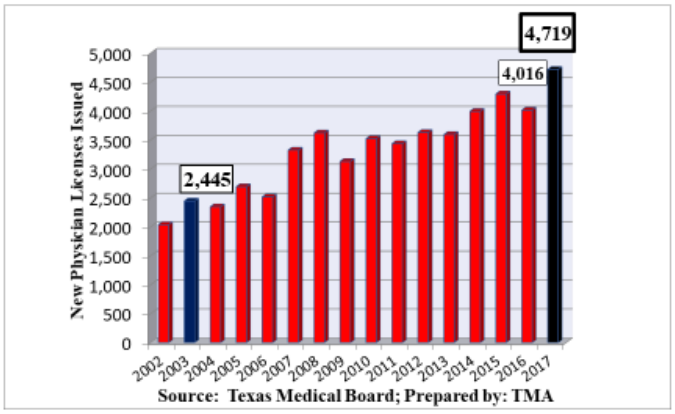
- Residents in training in Texas have grown by 22.8 percent over the past decade, from 5,993 to 7,357, and the number of programs from 471 to 590 (25 percent) — 1.5 times the national rate of growth.

FINDING: Texas reached another historic peak in the number of new medical licenses issued in fiscal year (FY) 2017.

Texas Medical Licensing Trends

Physicians continue to seek new medical licenses in Texas at the highest rate in the state's history, as reported by the Texas Medical Board. As shown in Figure 1, more than 4,700 new licenses were issued in the state fiscal year that ended Aug. 31, 2017. This was the highest ever and represented a net increase of 700 physicians or 17.5 percent over the previous year. The annual number of newly licensed has exceeded 4,000 for the past three years.

Figure 1: New Texas Physician Licenses, FY 2002-17



Texas licensed an annual average of 3,800 new physicians over the past decade. In comparison, the annual average was only 2,500 for the prior 10-year period. Since the passage of tort reform in 2003, Texas has licensed a cumulative total of 49,000 new physicians.

Medical school graduates in the United States continue to show a strong interest in Texas. In the 2017 survey of U.S. graduating medical students by the Association of American Medical Colleges, Texas ranked third among the state's most favored for practice by graduates, behind California and New York.

Of the 4,719 newly licensed physicians in FY 2017, a total of 1,189 were graduates of Texas medical schools. Table 1 contains a rank order of Texas medical schools by number of graduates among the 2017 newly licensed.

Table 1: Number of Newly Licensed Physicians by Texas Medical School Graduation, in Rank Order, Fiscal Year 2017

University of Texas Medical Branch, Galveston	196
University of Texas Southwestern Medical Center, Dallas	167
University of Texas McGovern Medical School, Houston	166
University of Texas Long Medical School, San Antonio	154
University of North Texas Health Science Center, Fort Worth	140
Texas Tech University Health Sciences Center, Lubbock	123
Baylor College of Medicine, Houston	120
Texas A&M University Health Science Center,	108
Texas Tech University Foster Medical School, El Paso*	15

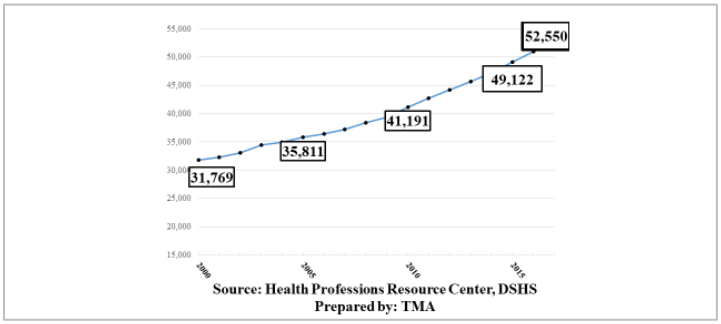
*Foster Medical School opened in 2009.

FINDING: The physician workforce is now growing faster than the state's population.

Growing Physician Workforce

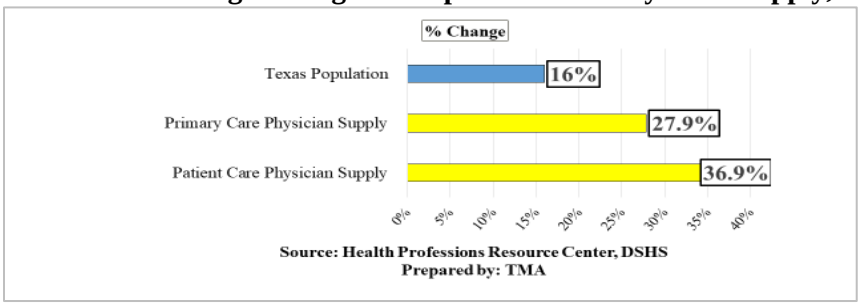
More than 82,000 physicians have a current Texas medical license. Of these, 52,550 report a direct patient care practice in the state. Physician supply has been growing at a steady rate for decades (Figure 2), with annual increases ranging from 3 percent to 5 percent over the past decade.

Figure 2: Texas Patient Care Physician Supply Trend 2009-17: Five-Year Intervals and 2017



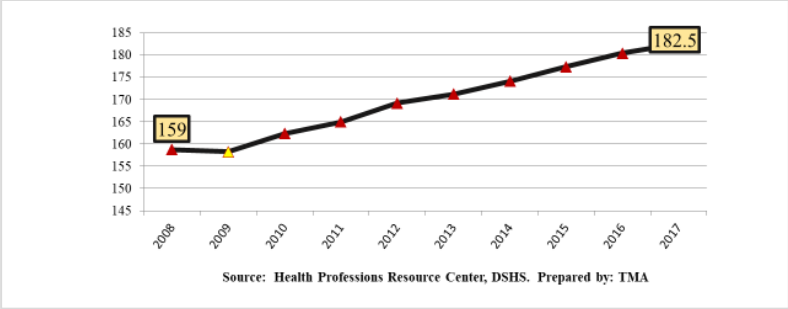
To assess the impact of the increased number of physicians on access to medical care, it is important to know how the growth in physician supply compared with increases in the state's population. During the past decade, the number of physicians grew at more than **twice** the rate of the state's population (Figure 3). The number of primary care physicians also grew at 1.7 times the rate of the state's population.

Figure 3: Texas Supply Growing Faster Than Population Comparison of Percentage Change for Population and Physician Supply, 2008-17



With physician numbers expanding at a rate exceeding the population growth, the ratio of physicians in direct patient care per 100,000 population increased nine of the past 10 years, reaching 182.5 in 2017 (Figure 4). This is an increase of 15 percent over the past decade. The committee views this as particularly significant given the robust growth in population. Texas led the nation in net population growth in the decennial censuses of 2000 and 2010, and in the 2015-16 population estimates. An improved ratio of physicians-to-population is critically important for expanding access to medical care for Texans.

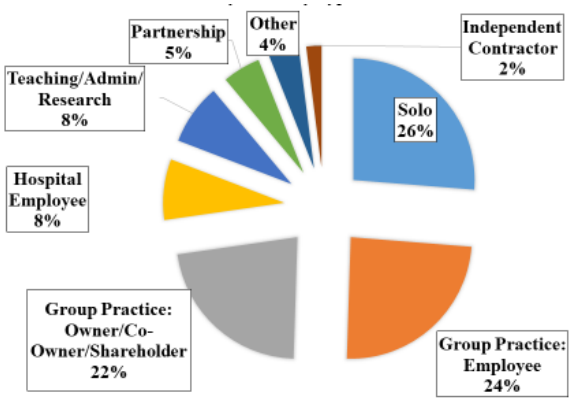
Figure 4: Texas Ratio of Patient Care Physicians per 100,000 Population, 2008-17



FINDING: Almost half of Texas physicians are members of a group practice.

As is commonly known, physicians have moved away from solo practice toward group practices. In Texas, 46 percent of physicians were part of a group practice in 2016 (24 percent are employees, and 22 percent had some form of ownership; see Figure 5). Only about one-fourth are now in solo practice. In contrast, 50 percent of Texas physicians were in solo practice in 1990.

Figure 5: Texas Physicians by Type of Practice, 2016



Source: TMA Biennial Physician Survey, 2016. Prepared by: TMA

Primary care physicians are slightly more likely to be in solo practice (29 percent), while about half of psychiatrists report a solo practice. Only 18 percent of psychiatrists were in group practices.

FINDINGS: Texas is among the nation's top states for retention of medical school graduates and residents following education and training. Despite positive physician growth trends, the state's ratio of physicians per capita remains in the bottom quartile of state rankings.

Texas ranks close to the top in the listing of states by retention rates for medical students and residents in the state for practice. For retention of medical students, Texas ranked second, behind California. Resident physicians were retained in the state at a rate of 58.7 percent, giving Texas a ranking of No. 5 in the country (Table 2). When both medical school and residency training are considered, Texas ranks No. 4 in the nation in retention for practice, with a retention rate of 80.9 percent. These rankings are based on an assessment of medical school and residency history for physicians who were practicing in Texas at one point in time — Dec. 31, 2016. Physicians may have relocated to Texas from other states before that date.

Despite recent successes in physician recruitment and retention, Texas continues to rank in the bottom quartile compared with other states for ratios of physicians per capita. This is largely a result of Texas' robust population growth as well as the challenge of overcoming longstanding physician supply shortages.

Table 2: Texas State Rankings for Medical Education and Workforce Indicators, 2017

Retention* of Physicians in Texas	State Ranking for Texas	Texas Physician Retention* Rate	U.S. Physician Retention Rate
From: Medical School	**No. 2** (California ranked No. 1)	59.9%	38.5%
From: Residency Training	**No. 5** (California, Alaska, Montana, and Florida rank above Texas)	58.7%	47.5%
From: Both Medical School and Residency Training	**No. 4** (Hawaii, California, and Arkansas rank above Texas)	80.9%	67.1%
Ratios of Active Patient Care Physicians by Specialty Groupings per 100,000 Population	**State Ranking for Texas**	**Texas Ratio per 100,000 Population**	**U.S. Ratio per 100,000 Population**
Physicians (All Specialties)	No. 41**	193.7	236.8
Primary Care Physicians	No. 47	65.4	82.5
General Surgeons	No. 48	5.5	6.7
Ratios per 100,000 Population	**State Ranking for Texas**	**Texas Ratio per 100,000 Population**	**U.S. Ratio per 100,000 Population**
Medical Students	No. 36	27.4	35.4
Residents and Fellows	No. 22	28.7	37.8
Patient Care Osteopathic Physicians	No. 31	14.4	18.7
Percentage	**State Ranking for Texas**	**Texas %**	**U.S. %**
Female Physicians	No. 23	33.9%	34.6%
Active IMG Physicians	No. 12	25.7%	24.5%

*Rankings are based on an assessment by Association of American Medical Colleges of medical school and residency history for physicians who were practicing in Texas at one point in time — Dec. 31, 2016. These physicians may have relocated to Texas from other states before that date.
**Only a slight improvement from the ranking of No. 42 a decade ago.
Source: 2017 State Physician Workforce Data Report, *Association of American Medical Colleges, November 2017.*
Prepared by: Texas Medical Association.

FINDING: Three more medical schools are in development in the state.

When the Foster Medical School opened in 2009 in El Paso, it was the first medical school in Texas in almost four decades. Since 2016, the number of medical schools in Texas increased by three, including the opening of two University of Texas allopathic schools in 2016. Both are small schools: Dell Medical School at UT-Austin with 50 students and Rio Grande Valley Medical School in Edinburg with 55 students. Both attained preliminary accreditation status from the Liaison Committee for Medical Education.

In fall 2017, the University of the Incarnate Word opened an osteopathic medical school in San Antonio with an inaugural class of 160 students and provisional accreditation from the American Osteopathic Association Commission on Osteopathic College Accreditation. The combined growth from the three schools lifted the number of medical schools in the state from 9 to 12, and added 265 students to the state's 2017 composite medical school class size, raising the total to 2,050. Since then, three more medical schools have been announced for Texas for 2019-20, as shown in Table 3.

Table 3: Three New Medical Schools Under Development in Texas, 2019 and 2020

Medical School	Inaugural Class Size	Opening Year
UNTHSC/TCU MD School, Fort Worth	60	2019
University of Houston MD School, Houston	30	2019
Sam Houston State DO School, Conroe	150	2020

The University of North Texas Health Science Center at Fort Worth (UNTHSC) and Texas Christian University (TCU) are jointly developing a new allopathic medical school in Fort Worth. Texas College of Osteopathic Medicine is currently part of UNTHSC in Fort Worth. The new school plans to admit 60 medical students in 2019, with 20 slots reserved for TCU students, and then build over time to a class size of 240.

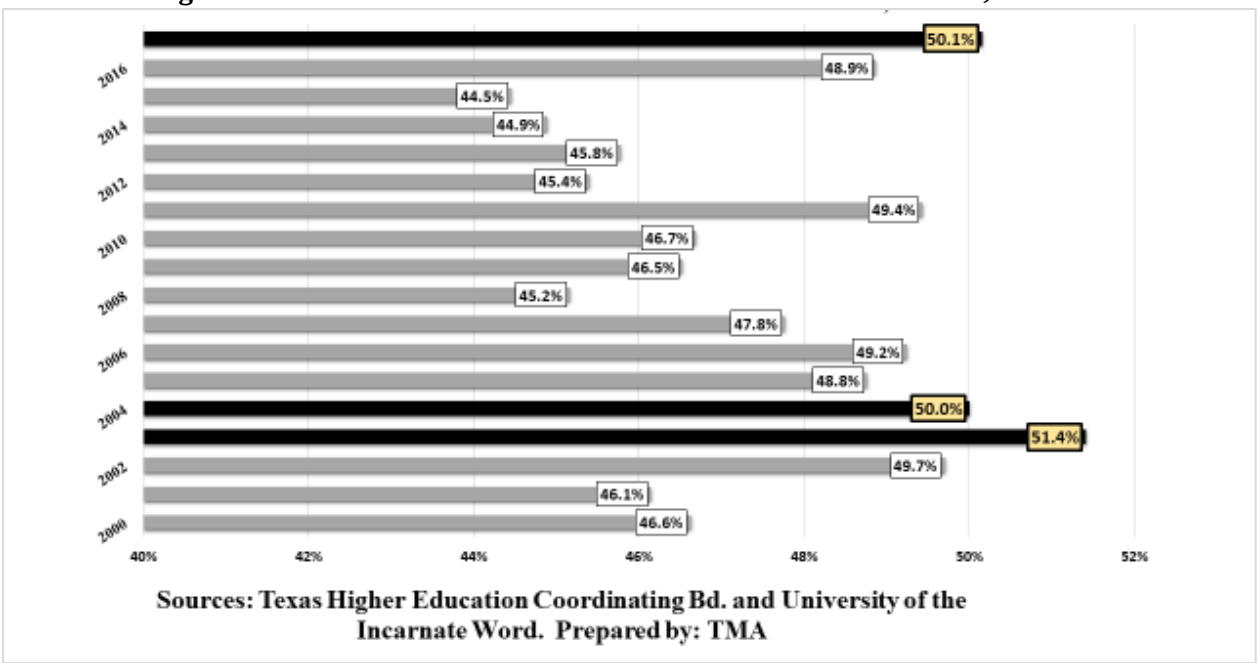
The University of Houston plans to open with 30 students in 2019 and add 30 more students each year from 2020 to 2022, to reach a peak class size of 120.

Sam Houston State University in Huntsville is developing an osteopathic medical school in Conroe, north of Houston, to open in 2020 with an inaugural class of 150.

FINDINGS: Slightly more women than men among first-year medical students in Texas for fall 2017 enrollments, and among applicants to Texas medical schools in 2017.

For the first time in 14 years and only the second time in Texas, there were more women than men among the first-year medical school students in Texas in Fall 2017. With 50.1 percent, women exceeded men by a razor-thin margin. Women exceeded men (51.4 percent) for the first time among first-year enrollments in 2003 and reached parity in 2004 (Figure 6). Women averaged 46.8 percent among first-year enrollments for the past 10 years in Texas.

Figure 6: Texas % Female First-Year Medical School Enrollments, 2000-17



Sources: Texas Higher Education Coordinating Bd. and University of the Incarnate Word. Prepared by: TMA

There were also slightly more women (50.3 percent) than men among the applicants to Texas medical schools in 2017. This marks the first time during at least the past decade when women topped men. (Note: applicant data were not available for Baylor College of Medicine.) For the first time, women also outnumbered men among first-year enrollments at the national level, with 50.7 percent.

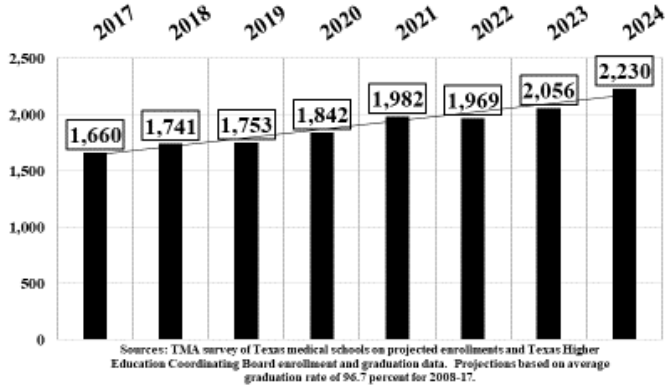
FINDING: Texas will continue to be challenged to expand graduate medical education (GME) capacity at the same rate as medical school enrollments with three new medical schools in development.

The number of residents training in the state is at historic levels, with a total of 7,357 residents in 590 residency programs (academic year 2015-16). Texas had an increase of 22.8 percent in residents over the past decade and an increase of 25 percent in residency programs. This growth is 1.5 times the rate of change for the national totals, with residents increasing by 15 percent and residency programs by 17 percent in the past decade.

Impact of More Schools on Graduate Medical Education Needs

Although GME capacity has expanded, there are concerns whether resources are available to boost GME to levels commensurate with the projected growth in medical school graduates. Texas Higher Education Coordinating Board recommends a ratio of 1.1 entry-level residency program positions for each Texas medical school graduate, or 10-percent above the total number of graduates. TMA also has policy in support of this goal. With the recent opening of three medical schools and three more schools currently in development, the state's total number of medical school graduates is projected to have a net increase of 570 (34.3%) from 2017 to 2024 (Figure 7).

Figure 7: TMA-Projected Medical School Graduates, 2018-24



Projected net growth, 2017-24: 570 (34.3%). *Note: 2017 is actual and not projected.*

A total of 237 new GME positions were created in the state from 2014 to 2017 through state grants provided to residency programs by the Texas Higher Education Coordinating Board. The Texas Legislature authorized a total of $97 million to support GME expansions in the 2018-19 state budget, a net increase of $44.05 million or 83 percent over the prior two-year budget. These funds are for the purpose of supporting the 237 new GME positions, and extremely little, if any, funding will be available to support the creation of more positions.

Additional positions also have been created without the use of state grants; however, how many is not known. The average annual growth in first-year GME positions offered in Texas in the annual allopathic match has been 69.5 from 2014 to 2017.

Texas Medical School Graduates Who Do Not Match to Residency Positions
Since 2014, the Council on Medical Education, in partnership with the medical schools, has monitored the number of Texas medical school graduates who do not match to a residency position. An annual average of 36 Texas medical school graduates (2 percent) were unable to match to a residency position during 2014-17. The reasons for nonmatches are varied and may not result from a shortage of training positions. Programs implemented at individual medical schools in recent years have shown success in reducing the number of no-matches. The council will conduct the post-match poll for 2018 in late March.

Texas Senate Bill 1066
Texas Sen. Charles Schwertner, MD (R-Georgetown), sponsored Senate Bill 1066, which the 2017 state legislature passed. This requires new medical schools to develop a plan for ensuring there are sufficient GME positions for the expected graduates. The Council on Medical Education will continue to monitor how the new schools ensure the state's GME capacity will be sufficient to accommodate the projected increase in the state's medical school graduates. Also, see the council's handbook report, Aligning Future Graduate Medical Education Capacity With Target Enrollments of New Texas Medical Schools.

FINDING: Compared with U.S. ratios, the Texas ratio of people-per-physician is the best for the specialty of interventional cardiology and the lowest for pulmonology.

To assess how Texas compares with the rest of the country in specialty distribution, the committee periodically calculates a comparison of Texas ratios of people-per-physician by specialty with ratios for the United States. This comparison is made by dividing Texas ratios of people-per-physician into U.S. ratios for 41 medical specialties, as reported by the Association of American Medical Colleges for 2017. The resulting percentages show if Texas is above, on par, in between, or low compared with the ratios for the country as a whole. A report showing the Texas/U.S. comparisons for all 41 medical specialties is attached.
Texas "bested" the United States with ratios for only two specialties, and six specialties were on par, or close to on par. Pulmonary disease had the lowest percentage, and psychiatry was next to lowest. *Note: Higher percentages are favorable for Texas; low percentages may signal specialty shortages.*

- Texas had **better** ratios of people-per-physician than U.S. totals for:
  - Interventional cardiology (Texas ratio is 107.8 percent of the U.S. ratio), and
  - Neonatal-perinatal medicine (103 percent).

- Ratios of people-per-physician in Texas were **on par, or close to on par,** with the U.S. ratios for:
  - Plastic surgery (98.8 percent of the U.S. ratio),
  - Nephrology (98 percent),
  - Pain medicine and pain management (97.4 percent),
  - Anesthesiology (96.5 percent),
  - Allergy/Immunology (95.8 percent), and
  - Neuroradiology (95.4 percent).

- Texas had the **lowest** ratios of people-per-physician compared with U.S. totals for:
  - Pulmonary disease (58.6 percent of the U.S. ratio), and
  - Psychiatry (60.5 percent).

There were variations in Texas percentages for the seven primary care specialties, with favorable percentages for geriatrics and obstetrics/gynecology and less favorable for internal medicine:
- Family/General medicine (86.4 percent of the U.S. ratio),
- Geriatrics (93.6 percent),
- Internal medicine (68.1 percent),
- Internal medicine-pediatrics (64.9 percent),

- Obstetrics/Gynecology (90.6 percent),
- Pediatrics (75.9 percent), and
- *Total primary care (80 percent).*

Compared with other specialty groupings, there was little difference in the Texas percentage for primary care (80 percent), medical specialties (80.5 percent), surgical specialties (81.8 percent), radiology specialties (82.3 percent), and all remaining specialties (80 percent).

Next Steps

The committee recognizes that TMA has multiple policy statements that support adequate GME capacity to accommodate the training needs of Texas medical school graduates along with policies that promote the retention of homegrown physicians in the state for practice. The workforce findings contained in this report will be shared with medical school, residency program, and teaching hospital representatives as a possible resource in making decisions about the development of future medical educational and GME programs. Analysis will continue to be done on an annual basis on the major physician workforce trends. Of particular interest is whether the state is successful in recruiting and retaining physicians to the extent that the physician supply continues to grow at a rate that exceeds the state's population growth. Results from these analyses will continue to be reported to the house and made available to the TMA membership.

ATTACHMENT Page 1

TMA Comparison of Ratios for Texas Population-Per-Physician with U.S. Ratios for 41 Medical Specialties, 2017

*Major Specialty Groupings, as Defined by AAMC**	*Patient Care Physician Supply*		*Ratio Population Per Physician*		*TX Ratio as % of U.S. Ratio*
	Texas	*U.S.*	*Texas*	*U.S.*	
Allergy and Immunology	384	4,647	72,559	69,535	*95.8%*
Anesthesiology	3,462	41,611	8,048	7,765	*96.5%*
Cardiovascular Disease	1,399	22,125	19,916	14,605	*73.3%*
Child & Adolescent Psych**	610	8,987	14,465	10,101	*69.8%*
Critical Care Medicine	714	10,855	39,023	29,768	*76.3%*
Dermatology	813	11,883	34,271	27,192	*79.3%*
Emergency Medicine	2,931	40,900	9,506	7,900	*83.1%*
Endocrinology, Diabetes & Metabolism	463	7,227	60,178	44,711	*74.3%*
Family/General Medicine	8,378	112,440	3,326	2,874	*86.4%*
Gastroenterology	990	14,398	28,144	22,443	*79.7%*
General Surgery	1,775	25,185	15,697	12,830	*81.7%*
Geriatrics***	342	5,364	9,805	9,181	*93.6%*
Hematology & Oncology	1,066	14,949	26,138	21,615	*82.7%*
Infectious Disease	505	8,803	55,173	36,707	*66.5%*
Internal Medicine	6,753	114,955	4,126	2,811	*68.1%*
Internal Medicine/Pediatrics	278	4,970	100,225	65,016	*64.9%*
Interventional Cardiology	328	3,528	84,947	91,589	*107.8%*
Neonatal-Perinatal Medicine	475	5,347	58,658	60,432	*103.0%*
Nephrology	879	10,403	31,698	31,061	*98.0%*
Neurological Surgery	406	5,395	68,627	59,894	*87.3%*
Neurology	819	13,563	34,020	23,824	*70.0%*
Neuroradiology	283	3,442	98,454	93,878	*95.4%*
Obstetrics/Gynecology	3,261	41,722	8,544	7,745	*90.6%*
Ophthalmology	1,253	18,704	22,237	17,276	*77.7%*
Orthopedic Surgery	1,290	19,086	21,599	16,930	*78.4%*
Otolaryngology	699	9,442	39,861	34,222	*85.9%*
Pain Medicine & Pain Management	414	4,930	67,301	65,543	*97.4%*
Pathology - Anatomic/Clinical	960	13,108	29,024	24,651	*84.9%*
Pediatrics**	4,279	57,979	2,062	1,566	*75.9%*
Physical Med & Rehab	637	9,281	43,740	34,816	*79.6%*
Plastic Surgery	602	7,069	46,283	45,710	*98.8%*
Preventive Medicine	423	6,592	65,869	49,018	*74.4%*
Psychiatry	1,982	37,962	14,058	8,512	*60.5%*
Pulmonary Disease	270	5,345	103,195	60,454	*58.6%*
Radiation Oncology	337	4,942	82,678	65,384	*79.1%*
Radiology & Diagnostic Radiology	1,898	27,654	14,680	11,685	*79.6%*
Rheumatology	365	5,727	76,336	56,422	*73.9%*
Thoracic Surgery	331	4,409	84,177	73,288	*87.1%*
Urology	675	9,837	41,278	32,848	*79.6%*
Vascular and Interventional Radiology	250	3,171	111,450	101,901	*91.4%*
Vascular Surgery	205	3,473	135,915	93,040	*68.5%*

See page 2 for footnotes.

ATTACHMENT Page 2

TMA Comparison of Ratios for Texas Population-Per-Physician with U.S. Ratios for 41 Medical Specialties, 2017

*Specialties with less than 10 physicians for Texas are not shown, excluding a total of 6,948 physicians and specialties with less than 25 physicians for the U.S. are not shown, excluding 96,206 physicians.

**Population <22 years of age were used in calculating the ratio

***Population 65+ were used in calculating the ratio

Methodology: Purpose of the report is to provide an assessment of how Texas compares to the U.S. as a whole in specialty distribution. Numbers of physicians by specialty are shown in the table, along with ratios of people-per-physician, by specialty. Texas ratios of people-per-physician by specialty were divided into the U.S. ratios to compare if Texas is above, on par, in between or low. Higher percentages are favorable for Texas and low percentages may signal specialty shortages in Texas.

Sources: "U.S. and Texas Physician Workforce Profiles, 2017" (containing Dec. 31, 2016 data), Assoc. of American Medical Colleges; and U.S. Census Bureau, July 1, 2016 Population Estimates.
***Prepared by:** TMA, 11/17.*

REPORT OF COMMITTEE ON EMERGENCY MEDICAL SERVICES AND TRAUMA

CM-EMST Report 1-A-18

Subject: Committee Activities Update

Presented by: Veer Vithalani, MD, Chair

Update on Trauma Centers

At 2018 TMA Winter Conference, the chair of the Governor's EMS and Trauma Council, Robert Greenberg, MD, and Texas Department of State Health Services (DSHS) Director of the Office of EMS/Trauma Systems Jane Guerrero provided an update on trauma-related issues. Of concern is that the number of Level IV trauma centers in rural areas has decreased over the past several years. In 2015, there were 55 Level III trauma centers and 198 Level IV trauma centers in the 254 counties across the state. Currently, there are 56 Level III trauma centers (only 19 are located in rural areas) and 193 Level IV trauma centers. In rural areas, DSHS has found that hospitals struggle to attract and maintain physicians to provide call coverage. The state trauma rules specify the minimum coverage requirements. At present, hospitals cannot use telemedicine to provide coverage. However, when the trauma rules undergo review later this year, the state will consider revisions to give rural facilities more flexibility.

Another concern raised was that small Level III facilities are performing complex surgeries potentially better managed at a higher-level facility. This issue also will be addressed during the trauma rule revision.

The committee continues to stay abreast of issues surrounding trauma centers.

Travel Screening Questions

Also during 2018 TMA Winter Conference, the committee discussed the need for a collective list of travel screening questions. Historically, there has not been a standard list of questions for use by hospital emergency departments or freestanding emergency departments. The committee collected questions from members and shared the list with the TMA Committee on Infectious Diseases to consider any further action from TMA.

Trauma Funding and the Driver Responsibility Program

The Texas Driver Responsibility Program (DRP) funds a majority of the state's trauma system. The DRP collects surcharges from Texans who violate driving laws, including driving while intoxicated and driving without a valid license or insurance. If the individual does not pay the fees within 105 days, his or her license will be suspended, which often creates a hardship on low-income Texans whose jobs require a drivers license or those who require a car to get to their place of employment.

Lawmakers of both parties as well as many county judges agree there are problems with the DRP and have worked to reform if not eliminate it. However, there also is recognition that eliminating the program would greatly affect the state's trauma system. Several bills filed during the 85th legislative session aimed to change, repeal, or replace the current DRP, but no bill passed both chambers. Two bills that gained legislative traction were Senate Bill 90 by Sen. Bob Hall (R-Edgewood), which repealed the DRP, and House Bill 2068 by Rep. Larry Phillips (R-Sherman) and Sen. Borris Miles (D-Houston), which repealed and replaced the DRP.

On Jan. 30, 2018, the Senate Finance Committee reviewed the state's trauma funding mechanism. Lawmakers of both parties discussed the chronic challenges for low-income Texans who drive without a license or insurance after a DRP fine and the subsequent burden that places on all Texan drivers.

Meanwhile, the committee recognized the state's reliance on the DRP's funding for the trauma system and the realities of what could happen if the funding stream dissipated. In 2019, there will be renewed efforts to reshape the DRP.

Stop the Bleed Day

Andrew Fisher, medical student, attended the committee's winter meeting to provide information on Stop the Bleed Day on Mar. 31, 2018. Stop the Bleed Day is a national event to encourage first responders and the public to take a bleeding control (B-Con) training class free of charge. The B-Con course trains volunteers and lay people how best to stop or decrease blood loss in victims injured during a mass casualty situation. At several recent mass shootings events, the quick responses by volunteers who acted to stop blood loss among shooting victims helped to save lives. The committee voted unanimously for TMA to devote time and resources to promote Stop the Bleed Day. TMA is currently promoting Stop the Bleed Day via social media messaging and blog posts.

State Responses to Hurricane Harvey

At several hearings in late 2017 and early 2018, frontline physicians who served Texans affected by Hurricane Harvey made several observations and recommendations for state agencies to improve the state's response in a future disaster. Of the many recommendations submitted, those relating to EMS and trauma included the need for more funding to rebuild and repair infrastructure damaged during the storm, as well as development of a system to ensure better coordinated and earlier evacuation of patients with special health care needs. According to EMS medical directors, due to poorly organized evacuation plans, Texas' EMS services operated inefficiently, resulting in higher costs and potential injury or death for first responders or patients.

REPORT OF COMMITTEE ON MEDICAL HOME AND PRIMARY CARE

CM-MHPC Report 1-A-18

Subject: Committee Activities Update

Presented by: Lindsay Botsford, MD, Chair

The State of Primary Care in Texas

Discussions regarding the capacity and availability of primary care in Texas have been an ongoing activity of the Committee on Medical Home and Primary Care. To ascertain the state of primary care and medical homes in Texas, the committee collaborated with multiple stakeholders, including the Texas Academy of Family Physicians, Texas Pediatric Society, Texas Chapter of the American College of Physicians, Texas Association of Obstetricians and Gynecologists, and American College of Obstetricians and Gynecologists Chapter XI (Texas), with the goal of developing potential 2019 legislative recommendations. The resulting report will highlight the current primary care physician shortage, including efficacy of Texas' existing recruitment and retention efforts; impact of low payment rates; and opportunities and pitfalls of a changing health care delivery landscape, such as expanding use of telemedicine. The Primary Care Coalition previously released three reports on the topic: *Fading Away* (2002), *Fractured* (2006), and *The Primary Solution* (2008).

Texas Medical Home Summit

The sixth annual Texas Primary Care and Health Home Summit presented by the Texas Medical Home Initiative and Texas Health Institute is April 5-6, 2018, in Austin. TMA served on the planning committee and assisted with the speaking agenda. The focus of the summit is expanding access to high-quality, person-centered primary care for individuals and families in Texas. Further, attendees receive exposure to best practices for innovation in primary care and interact with program experts at various stages of medical home implementation. This is an event attended by several committee members.

Effective Pain Management in a Primary Care Practice

As the nation continues to face challenges with opioid and prescription drug overuse and its consequences, physicians are looking at current pain management practices in primary care. In Texas in 2014, 4.2 per 100,000 people died from drug overdose involving opioids. Compared with the national average of 8.8 per 100,000 people in 2014, Texas had a lower overdose death rate than the national average. Yet, experts in the field argue that looking only at overdose deaths ignores the prevalence of substance use disorders and opioid misuse. In fact, four of the nation's 25 cities with the highest levels of opioid abuse (based on percentage of prescriptions abused) are in Texas: Texarkana (No. 10), Amarillo (No. 13), Odessa (No. 15), and Longview (No. 17).

At 2018 TMA Winter Conference, Daniel Crowe, MD, a medical director with Superior Health Plan and recognized leader in addressing the opioid epidemic, presented a new paradigm for managing chronic pain and substance abuse disorders in primary care settings. This approach emphasizes substance abuse screening; early intervention; and treatment using nonopioid medications and other interventions, such as cognitive-behavioral and physical therapy. Dr. Crowe helped coordinate a three-day summit on the intersection of chronic pain management and substance use in January 2018.

Recognizing the need for further investigation on opioid and substance use by the Texas Legislature, House Speaker Joe Straus created the Select Committee on Opioids and Substance Abuse. Other legislative committees are focusing on the issue in addition to the select committee. TMA was invited to provide expert testimony to the Senate Committee on Health and Human Services in March 2018 on

opioid and substance use in Texas. In response, the Medical Home and Primary Care Committee created background information describing how opioid and substance use issues can begin unintentionally in the medical setting. The committee will continue to work on this issue throughout the interim.

Postpartum Depression Screening

In 2017 during the 85th legislative session, passage of House Bill 2466 (Davis/Huffman) was a priority for TMA. HB 2466 allows a physician to bill Medicaid for a maternal depression (also known as postpartum depression or PPD) screening during a well-child visit or other office visit before the child's first birthday. This allows a mother to receive an optional maternal health screening regardless of her Medicaid status. TMA worked with other stakeholder groups on the bill, including the Texas Pediatric Society, American College of Obstetricians and Gynecologists, Texas Association of Obstetricians and Gynecologists, and Texas Academy of Family Physicians. The legislature passed HB 2466, and Gov. Greg Abbott signed the bill into law on June 15, 2017.

Since then, TMA has worked with stakeholder groups and agency staff to ensure effective implementation of the new law. TMA submitted comments in December 2017 with the stakeholders mentioned above to the Texas Health and Human Services Commission on the draft rules related to the maternal depression screening. The comments recommended that the state (1) ensure the American Academy of Pediatrics-recommended number of screenings are available for billing, (2) provide instructions on how to refer women to mental health services if needed after the screening, and (3) communicate to local mental health authorities that women diagnosed with PPD fall under the primary diagnosis of major depressive disorder.

REPORT OF PATIENT-PHYSICIAN ADVOCACY COMMITTEE

CM-PPA Report 1-A-18

Subject: Patient-Physician Advocacy Update

Presented by: R. Larry Marshall, MD, Chair

The Patient-Physician Advocacy Committee presents the following informational report regarding the committee's recent actions.

Texas Medical Board

The committee has been involved with the Texas Medical Board (TMB) to learn more about its processes and procedures and to offer improvements. The committee also provided input into the Texas Medical Association's advocacy 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.

Board Certification Issues

The committee has been in communication with the American Board of Medical Specialties (ABMS) on standardizing due process requirements across its member boards and on more clearly defining the consequences that medical board license action has on a physician's board certification. The committee heard from a physician whose board certification was revoked after entering into an agreed order that required the physician to pay an administrative fine, take the jurisprudence exam, and complete eight hours of continuing medical education. The physician's specialty board considered those terms to be a "license restriction." The committee, in a letter to ABMS, encouraged ABMS and its member boards to adopt a safe harbor for minor licensure actions, so that if a physician agrees to certain actions by the medical board, the physician can be more aware of the possible consequences of that agreement with respect to board certification.

Hospital-Physician Relations

The committee has considered issues involving conflicts between physicians and hospitals regarding physician hospital privileges. The committee has heard several cases in which physicians alleged their privileges were wrongfully revoked or not renewed. The committee has considered amicus involvement in these cases. The committee has considered laws relating to lawsuits between physicians and hospitals and also has developed guidance on behavioral standards — what previously had been called "disruptive physician" standards.

REPORT OF COMMITTEE ON RURAL HEALTH

CM-RH Report 1-A-18

Subject: Committee Activities Update

Presented by: Sandra Dee Dickerson, MD, Chair

Update on Rural Physician and GME: Recruitment and Retention

Addressing challenges of rural physician recruitment and retention is a top focus for the committee. At 2018 TMA Winter Conference, O.W. "Skip" Brown, MD, provided the committee with an overview of the Rural Health Care Track at The University of Texas Medical Branch (UTMB) Medical School. The goal of this track is to introduce students to the practice of medicine in smaller communities by allowing the student to choose a single rural community in which to complete multiple clerkships. The program seeks to expose students to the realities of small community life, including nonacademic sites and the community in general. Long-standing relationships with patients and their families are a unique feature of small communities, which the program attempts to highlight through these clerkships. The committee considered how to incorporate lessons learned from the UTMB program to similar programs across the state, as well as the potential to replicate the UTMB program in other medical schools. At 2018 TMA Winter Conference, committee members identified ways to improve recruitment efforts in rural areas, including the need to have an up-to-date residency slot registry specifically for rural areas. As the committee notes, many medical school graduates find only outdated information online related to rural practice and do not know what options are available to them. The committee will be continuing its efforts related to this issue, including the potential creation of a rural residency slot registry.

Telemedicine Rules Update

A comprehensive telemedicine bill passed in the 85th legislative session. Senate Bill 1107 by Sen. Charles Schwertner, MD (R-Georgetown), and Rep. Four Price (R-Amarillo) made statutory changes to promote expansion of telemedicine in the state, including updating the delivery modalities acceptable for payment, patient and distant site guidelines, patient site presenter requirements, prescribing practices, and the patient-practitioner relationship. SB 1107 expanded the definition of telemedicine and removed the blanket requirement for in-person or face-to-face visits. However, the medical board is still authorized to ensure that "patients using telemedicine medical services receive appropriate, quality care." According to the new law, health care payers must adopt and post telemedicine policies and payment practices. Later this year, Texas Medicaid will revise its rules and policies to conform to the new statute and broaden availability of telemedicine services. TMA will work closely with the Texas Health and Human Services Commission on the Medicaid-related rules. For commercial plans, Texas law requires parity for face-to-face and telemedicine exams, meaning a health plan cannot deny a claim for service just because it was made via telemedicine, though SB 1107 did explicitly exclude coverage if the telemedicine service is only audio interaction (synchronous or asynchronous) or facsimile. Health plans also must prominently post on their websites their payment protocols and policies for telemedicine. TMA will continue to monitor telemedicine changes within commercial plans.

State Responses to Hurricane Harvey

While physicians give the state high marks for its overall response to Hurricane Harvey, frontline physicians who served Texans affected by the disaster have provided TMA numerous observations and recommendations for how state agencies can improve their responses to disasters in the future. TMA has shared these reform proposals with several legislative oversight committees, including the Senate Health and Human Services Committee and House committees on Public Health and County Affairs. According to TMA's post-storm survey, 67 percent of affected rural physicians temporarily closed their practices

following the disaster. TMA's recommendations related to rural health include the need for more funding to help displaced practices and to repair health care infrastructure damaged during the storm. TMA also recommended changes that will help the Texas Medical Reserve Corps (MRC) deploy quickly in hard-hit small and rural towns. MRC consists of community-based units that organize locally and use volunteer medical and public health professionals to strengthen public health and emergency response after a natural disaster. MRC volunteers supplement existing emergency and public health resources. Physicians noted that in the Harvey aftermath, urban areas maintained active MRC units, but such units are not necessarily present in other areas of the state, resulting in slower deployment of volunteers in hard-hit small and rural towns. TMA's recommendations for MRC are to educate physicians and smaller communities about MRC; establish easily activated mobile units; and house MRC units within governmental institutions, as most government entities remain functional during disasters.

REPORT OF TEXPAC

TEXPAC Report 1-A-18

Subject: TEXPAC March Primary Summary Report

Presented by: Robert Rogers, MD, Chair

The outcome of the March primary resulted in huge victories for TEXPAC and for medicine. This election cycle was unpredictable, with the departure of House Speaker Joe Straus bringing much uncertainty. Texas saw a large increase in voter turnout in the Democrat primary, totaling 1 million voters, although the total Republican turnout still significantly out-performed the other side with 1.5 million votes cast. Overall, TEXPAC had a 93-percent success rate in keeping our endorsed candidates in the running for the November elections.

TEXPAC helped secure victories in House Republican primary races for our champions:

- J.D. Sheffield, DO (HD 59, Gatesville)
- Sarah Davis (HD 134, W. University Place)
- Lyle Larson (HD 122, San Antonio)
- Chris Paddie (HD 9, Marshall)
- Ken King (HD 88, Canadian)
- Four Price (HD 89, Amarillo)
- Charlie Geren (HD 99, Fort Worth)
- Giovanni Capriglione (HD 98, Southlake)
- Linda Koop (HD 102, Richardson)
- Mary González (HD 75, Clint)
- Ryan Guillen (HD 31, Rio Grande City)

TEXPAC also was instrumental in the primary victories of three House freshman who had opponents — Ernest Bailes (HD 18, Huntsville), Hugh Shine (HD 55, Temple), and Lynn Stucky (HD 64, Denton).

TEXPAC lost five incumbents who were true friends of medicine. We will see the departure of House members Wayne Faircloth (HD 23, Galveston); Roberto Alonzo (HD 104, Dallas); Jason Villalba (HD 114, Dallas); Diana Arevalo (HD 116, San Antonio); and Tomas Uresti (HD 118, San Antonio), as well as Craig Estes (Senate District 31, Wichita Falls) in the Senate.

This election was one of the most expensive and aggressive cycles Texas has ever seen. More than $67 million was spent in this election as a whole — including $21 million on the governor's race. A total of $21 million was spent in House races and $10 million in the Senate. TEXPAC spent $525,000 in contributions to buy newspaper ads, send mailers, and sponsor fundraisers for our endorsed candidates.

However, despite the efforts of TEXPAC, medicine needs to face some harsh realities. The fringe groups are rapidly getting stronger, and the only way TEXPAC can combat them is to increase our membership. Increased membership means TEXPAC will have more money to contribute to our candidates so they can defeat the enemy.

Unfortunately, two TEXPAC-endorsed House incumbents, Reps. Scott Cosper (HD 54, Killeen) and Rene Oliveira (HD 37, Brownsville), were unable to avoid a runoff, and they will appear on the May 22

election ballot along with seven other House races and eight congressional. TEXPAC is aggressively fundraising for the runoff elections with a goal of raising $50,000.

For the 17 races, TEXPAC is primed for involvement where there is a clear distinction between the two candidates and their views on health care and/or there is strong local physician input.

These are **(TEXPAC-supported candidates are in boldface):**

- CD 2 **Kevin Roberts** vs. Dan Crenshaw
- CD 5 **Lance Gooden** vs. Bunni Pounds
- CD 6 **Jake Ellzy** vs. Ron Wright
- HD 4 **Keith Bell** vs. Stuart Spitzer, MD
- HD 8 **Cody Harris** vs. Thomas McNutt
- HD 13 **Ben Leman** vs. Jill Wolfskill
- HD 37 **Rene Oliveira** vs. Alex Dominguez
- HD 54 **Scott Cosper** vs. Brad Buckley
- HD 62 **Reggie Smith** vs. Brent Lawson
- HD 121 **Steve Allison** vs. Matt Beebee

REPORT OF TEXAS MEDICAL ASSOCIATION INSURANCE TRUST

TMAIT Report 1-A-18

Subject: Texas Medical Association Insurance Trust 2017 Annual Report

Presented by: Bernard M. Gerber, MD, Chair

Background and Organization

The Texas Medical Association Insurance Trust (TMAIT) operates under the authority of an eight-member board of five trustees appointed by TMA and three trustees elected by the trust's subscribers. The five appointed trustees include the executive vice president of TMA and a member of the TMA's Young Physician Section. During 2017, the trustees met in person in January, May, and September in conjunction with TMA conferences and the House of Delegates meeting. In addition, the trustees held their annual three-day planning session in 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., 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.

2017 Financial Results

Overall, the insurance program experienced a gain of about $9.4 million in 2017 compared with a gain of about $7.7 million in 2016. The 2017 gain was largely attributable to exceptionally positive results for the LTD plan. The results by plan, with comparative information for 2016, are presented below.

- The life insurance plan experienced a gain of about $2.7 million for 2017 compared with a gain of about $500,000 in 2016. There were 20 death claims in 2017 compared with 26 in 2016. The total payments in 2017 were $2.4 million, which is considerably lower than the $6.2 million paid in 2016.
- The business overhead plan experienced a gain of about $125,000 during 2017 compared with a gain of about $1 million during 2016.
- The LTD plan experienced a gain of $7.2 million in 2017 which is only slightly less than the $7.4 million gain it experienced in 2016. The gain in 2017 resulted from a low number of new claims (only eight) and an exceptionally high number of terminating claims (30, including four of the new claims, which were in payment status for less than one year). Terminations occur as a result of recovery, death, or reaching the end of the benefit period.
- In 2017, the health plans produced a loss of about $800,000 compared with a loss of $1.3 million in 2016. 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 2017 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 2017 policy year (Oct. 31, 2017), the insurance program had a combined PSF balance of $88.9 million.

2017 Program Initiatives and Accomplishments

Effective Nov. 1, 2017, TMAIT implemented the following enhancements to the Business Overhead Plan:

- We increased the maximum monthly benefit amount from $35,000 to $50,000.
- Salary for replacement doctors (locum tenens) is now a covered expense.

TMAIT was recognized by the Professional Insurance and Marketing Association (PIMA) for excellence in marketing at the 2017 Marketing Methods Competition. PIMA convenes the leaders and leading companies in affinity benefits distribution and direct marketing. TMAIT was awarded the Gold Award for New Media and the Best of PIMA for Excellence in Marketing.

2018 Initiatives

In 2018, we continue to improve marketing and administrative services for our members.

- We will continue our transition from mass marketing by product to focused marketing by member segment. This will lead to more relevant communication with members and an increase in the value we provide.
- TMAIT established a strategic partnership and funding mechanism with the TMA Education Center to promote no-cost or reduced-cost access to TMA's online continuing medical education courses. For its investment, TMAIT will have exclusive advertising and promotional rights on most TMA Education Center properties. This should help increase awareness of the trust among members and lead to more service and participation opportunities.
- TMAIT continues the expansion of products we offer to members. In 2018, we intend to launch six new products with Prudential, a group benefits program with The Hartford, and a suite of noninsurance protection products from New Benefits, Ltd.

We will continue to closely monitor legislative developments related to the Affordable Care Act (ACA) and the executive order related to association health plans (AHPs) throughout 2018. 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, which were 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 they have in the past. The association group health plans and the assistance we provide in securing coverage in the individual and small-group market have allowed our staff to maintain a high level of expertise in the health insurance business. This places TMAIT and the agency in a great position to respond to any changes that may arise from any renewed efforts to “repeal and replace” the ACA or the expansion of AHPs.

Attachment A

TMAIT Statistics

Benefit Payments

Plan	2017 Benefit Payments (Millions)
Health	$8.8
Long Term Disability (LTD)	4.1
Life	2.4
Business Overhead	0.5

Miscellaneous

Total Contributions	$23.3 million
Combined Premium Stabilization Fund	$88.9 million

2017 Program Highlights

Rate of Return on Invested Assets	3.0%
LTD Payments	1,047
Disabled Physicians Receiving LTD Payments	76
New LTD Claims	8
Death Claims	17
Applications	1,477
Coverage Quotes	2,906
Billings	27,378

2017 Enrollment by Plan

Plan	Enrollment
Life Insurance	4,121
Long-Term Disability	4,097
Business Overhead	750
AD&D	1,680
Health	1,526
Dental	883
Vision	56

REPORT OF TEXAS MEDICAL ASSOCIATION FOUNDATION

TMAF Report 1-A-18

Subject: TMA Foundation 2017 Annual Report

Presented by: Leslie H. Secrest, MD, President

Funds Raised and New Fund Established in 2017

The TMA Foundation raised nearly $2.3 million in 2017, the second highest amount in its history. Thanks to the generosity of Roberto J. Bayardo, MD, Houston, the TMAF Hispanic Nursing Scholarship Trust Fund of Dr. Roberto J. and Agniela (Annie) M. Bayardo was established in 2017 to award nursing scholarships to students in Travis and Harris counties by the Travis County Medical Society Alliance and the Harris County Medical Society Alliance respectively. This new fund is part of the recently established TMAF Family of Funds that supports the philanthropic aspirations of TMA and TMAA members and TMA's vision to improve the health of all Texans.

Grants to Support TMA 2017 Programs

The generosity of donors, plus investment earnings from endowments, enabled TMAF to make $968,933 in grants to support programs that primarily were carried out in 2017. This is highest level of grant support since 1994, when TMAF paid its first grants in the amount of $278,933.

Included among the 2017 grants is $893,992 for 10 TMA health improvement, quality-of-care, and science initiatives, including the special disaster relief efforts in the wake of Hurricane Harvey. This is 64 percent more than the $546,470 in grants to TMA for its 10 2016 programs.

For every $1 TMA invested in TMAF in 2017, TMA receives nearly a 10-fold benefit in community health improvement and positive physician image.

Foundation grants supported these 2017 TMA programs:

- Hard Hats for Little Heads,
- Be Wise — Immunize[SM],
- 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,
- Disaster relief,
- History of Medicine *Deep Roots* exhibit guide, and
- Maternal Mortality and Morbidity Forum.

Grants Paid to Support the Family of Medicine and First Matching Grant

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 their local community health improvement programs. Under these 2017 grant programs, TMAF approved $32,904 in grant support for nine programs, with a portion of these grants paid out in 2018.

The TMAF Hispanic Nursing Scholarship Trust Fund of Dr. Roberto J. and Agniela (Annie) M. Bayardo awarded $31,600 for seven scholarships.

TMAF's first matching grant was awarded to the Tarrant County Medical Society for its Project Access Tarrant County (PATC). The $10,000 matching grant is made possible thanks to generous donors to TMAF's General Endowment. The matching grant helped Tarrant County Medical Society attract new donors and encouraged existing donors to increase their support to raise the $10,000 required to win TMAF's matching grant of $10,000. Through the generosity of more than 200 volunteer physicians and other donated services, PATC helps low-income and uninsured individuals in Tarrant County receive needed specialty care.

Additional TMAF achievements include:

- Raising more than $326,000 through the 2017 gala, thanks to generous sponsors, nearly 500 guests, and the efforts of the TMA Foundation Board of Trustees. Top sponsors were H-E-B, Pfizer, Inc., and Texas Medical Liability Trust.
- Adding expertise to its board of trustees with new members Carla F. Ortique, MD, Houston, and Steven H. Kelder, MPH, PhD, Austin, as well as representatives from the TMA Resident and Fellow Section and TMA Medical Student Section.
- Approval of grants to support TMA's 2018 health improvement, quality-of-care, science, and education initiatives as well as Family of Medicine community programs. See Attachment A.
- Reaching a new record of 27 individuals as new or upgraded Major Donors (23 in 2016); each were recognized at 2018 TMA Winter Conference, and their names will be 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 219 as of Dec. 31, 2017. Major Donor status begins at $10,000 in cumulative donations with additional levels for subsequent increased giving; see Attachment B.
- Presenting the 2017 TMAF John P. McGovern Champion of Health Award; grants of $5,000 and $2,500 were presented for winning programs that improve student health and nutrition.

TMAF's 25th Anniversary Gala on Friday, May 18, 2018

TMA Foundation's 25th annual gala celebrates 25 years of turning good ideas into better health. The event takes place on Friday, May 18, at the JW Marriott San Antonio Hill Country Resort & Spa during TMA's TexMed. Sheldon Gross, MD, and Georgiana Gross and Jayesh Shah, MD and Neha Shah, all of San Antonio, are co-chairing the event. The lead sponsor for the event is H-E-B. Confirmed sponsors from the $30,000 level to the $2,000 level as of April 10, 2018, are: H-E-B; Pfizer, Inc.; Texas Medical Liability Trust; Baylor Scott & White Health; TMA Insurance Trust; UnitedHealthcare; Baptist Health System; Blue Cross and Blue Shield of Texas; Pathology Reference Lab; Pediatrix Medical Group of Texas, San Antonio; Prudential; Texas Health Resources; Texas MedClinic; Travis County Medical Society; Joe R. & Teresa Lozano Long School of Medicine, UT Health San Antonio; Abbott; Austin Geriatric Specialists, in honor of Dr. Peggy Russell; Baylor College of Medicine; Bell County Medical Society; Bexar County Medical Society; CHRISTUS Santa Rosa Health System; Frost; Martin G Guerrero, MD, and Carol A. Guerrero; Hidalgo-Starr County Medical Society; Houston Academy of Medicine/Harris County Medical Society; Jackson Walker LLP; Kelsey-Seybold Clinic; Luther King Capital Management; Methodist Children's Hospital; Carla F. Ortique, MD; The Quantitative Group at Graystone Consulting; Dr. Steve and Sharon Robinson; Rudd & Wisdom, Inc.; TMF Health Quality Institute; Texas Oncology, PA; TEXPAC; Texas Tech University Health Sciences Center School of Medicine dean; University Health System; University of the Incarnate Word School of Osteopathic Medicine; University of North Texas Health Science Center; UTMB Health; Vaughan Nelson Investment Management; Charles W. "Bill" Bailey Jr., MD, in honor of UTMB; Douglas and Sandy Curran; TMA International Medical Graduate Section, Sejal Mehta, MD, MBA, chair; Russell W.H. Kridel, MD; Lee Ann Pearse, MD, and Einar Vagnes; Regina Rogers, in honor of Mark Kubala, MD; Dr. and Mrs. Jayesh

Shah; Texas Indo-American Physicians Society, SW Chapter; Texas Medical Association, in honor of Douglas W. Curran, MD; Texas Medical Association, in honor of Sunshine Moore; Texas Medical Association, in honor of Surendra K. Varma, MD; and Daniel Vijjeswarapu, MD.

In the predinner receptions, guests will have the opportunity to enjoy the silent auction and buy their chance to participate in a new activities — Sip & Sparkles and Kendra Scott Mystery Boxes. In the ballroom, guests may bid in the live auction and donate to the Make-A-Difference drive, which supports TMA's Hard Hats for Little Heads.

The event is the single largest fundraising effort of TMAF and makes TMA health improvement, science, and quality-of-care programs possible.

Through April 30, regular individual tickets are $220 each and special VIP access tickets are $270; after April 30 these increase to $245 and $295 respectively. Individuals may sponsor a table of eight for $2,000. For more information and to purchase tickets, contact TMA Foundation at (800) 880-1300, extension 1466 or (512) 370-1466.

Attachment A

TMA GRANTS — *In support of TMA's public health and science priorities*

TMA's Be Wise — Immunize (BWI): BWI is a public health initiative that promotes the importance, safety, and effectiveness of vaccinations. The program combines education for physicians and patients with hands-on vaccination clinics (sponsored by physicians, TMA Alliance members, and medical students) to increase Texas' vaccination rates. Since its beginning in 2004, Be Wise — Immunize has provided nearly 340,000 vaccinations to Texas children, adolescents, and adults. The program supports TMA and TMA Alliance members with grants to fund local shot clinics aimed at Texas' underserved and uninsured populations.

TMA's Hard Hats for Little Heads (HHLH): HHLH encourages exercise and fitness and helps prevent life-altering or fatal brain injuries in Texas children. Since the program's inception in 1994, more than 285,000 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.

NEW! TMA's HPV Social Media Campaign: To support the public education component of TMA's HPV Working Group, TMA's Council on Health Promotion, along with TMA's Be Wise — Immunize, developed a social media campaign to increase awareness among parents and older teens/young adults of the importance of human papillomavirus (HPV) vaccination to prevent cancer. The social media campaign ran in Tyler and San Angelo — college towns with worse-than-average HPV vaccination rates — in the first quarter of 2018, targeting 17- to 22-year-olds in those markets to urge them to get vaccinated.

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-five 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 handouts.

University of Health Forum: 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 forums.

NEW! History of Medicine Banner Program: This program will enable TMA's History of Medicine Committee to offer the seven educational banner sets to schools and libraries to enhance the image of the physician and encourage the pursuit of research and science education. The banners are an invaluable means of promoting TMA goals of patient health advocacy by way of education and historical content.

Texas Two Step: This initiative by the Texas College of Emergency Physicians and HealthCorps provided skills training to community participants on how to act quickly in the event of cardiac emergencies by following two easy steps: (1) call 911, and (2) initiate hands-only CPR. The program expanded in 2018 to replicate the event on a national level. The project has trained more than 20,000 Texans on how to save lives with hands-only CPR.

Attachment A (continued)

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 groups to provide an efficient method for residents to receive the influenza vaccine. The "drive-thru" shot clinic will reach 400 citizens, aged 18 or older. The easy-access option will be a particular asset to both the elderly and a vast majority of the rural community who find it difficult to visit a regular, walk-in clinic.

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 otherwise would be unable to access.

NEW! Lubbock Anti-Sex Trafficking Project/Lubbock County Medical Society. This project raises awareness about the problem of human sex trafficking of minors in Texas. Lubbock County Medical Society is collaborating with several local organizations to facilitate a unified call to action to make Lubbock and West Texas a safe haven for children and a user-unfriendly town for buyers and sellers of children for sex trafficking.

Immunization Collaboration of Tarrant County (ICTC)/Tarrant County Medical Society Alliance Foundation. This program provides: (1) low-cost vaccine events that help eligible children and adults receive required vaccines for kindergarten, seventh grade, and college school registrations; more than 7,000 eligible children and adults are served; and (2) vaccine education for parents, community, health care workers, and providers, ongoing and growing through website and social media channels so that ICTC becomes a go-to source for information about the importance and safety of immunizations.

NEW! Power for Parkinson's/Travis County Medical Society. Power for Parkinson's provides free Parkinson's group fitness and dance classes, singing groups, and social activities for people with Parkinson's disease and their care partners in Austin and surrounding communities. The program mission is to engage people with Parkinson's in regular exercise to slow or even reverse the symptoms of the disease, improve overall sense of well-being, and provide opportunities for socializing to help prevent the depression and isolation that often accompany the disease.

TMA MEDICAL STUDENT CHAPTERS — *Medical Student Community Leadership Grants*

Alliance Refugee Wellness Fair/Baylor College of Medicine. This annual event addresses health care disparities in the underserved refugee population that has resettled in Harris County by providing direct medical and preventive health services, education about health and well-being, and resources for greater access to medical care. In partnership with several nonprofit refugee resettlement agencies in the area, this initiative will provide refugees with culturally competent resources to navigate the Harris Health System.

Aggie Health Project: Hepatitis C/Texas A&M Health Science Center College of Medicine. In conjunction with Martha's Clinic, Texas A&M's student-run free clinic, this initiative aims to add hepatitis C to current health maintenance screenings and, when applicable, appropriate referral to community partners for the homeless and indigent of the city of Temple and Bell County. The addition of this screening addresses a disparity in available preventive services, creating opportunities for care and cure.

HOPE Health Fair/The University of Texas Medical Branch. This collaborative event will provide vaccines, health screenings, and a meal to homeless and uninsured individuals living in Galveston. The UTMB TMA Chapter, Family Medicine Interest Group, and Gold Humanism Honor Society will work with St. Vincent's Student Clinic (run by students) to host the second annual HOPE (Helping Others Through Partnered Empowerment) Health Fair. Last year, more than 200 vaccines were provided to this community, and this year the TMA chapter hopes to serve at least 250 individuals through this campaign.

Frontera de Salud/McGovern Medical School TMA Medical Student Section. Frontera de Salud is a student-based community health project that addresses health disparities and promotes healthy living on the Texas-Mexico border. The program provides an opportunity for medical and public health students to practice skills and apply knowledge toward meeting the health needs of the community. The program partners with the UTHealth School of Public Health and Cameron County Health Department to provide quarterly health screenings, home visits, and community assessments.

Attachment B

TMA Foundation Major Donors

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Attachment B (continued)

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Dr. Dale and Mrs. Mertie L. Wood

*Deceased

REPORT OF TEXAS MEDICAL ASSOCIATION ALLIANCE

TMAA Report 1-A-18

Subject: TMA Alliance Activities and Accomplishments

Presented by: Karen Lairmore, President

Public Health Outreach

The TMA Alliance, partnering with community organizations including local health departments and immunization coalitions, has contributed to more than 340,000 immunizations administered to the state's children since the inception of Be Wise — Immunize[SM] in October 2004.

As a major participant in the Hard Hats for Little Heads program, TMAA helped to distribute almost 30,000 helmets to Texas youth in 2017. And since 1994, TMA and TMAA have distributed more than 285,000 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, and bullying. Members also educate the public about smoking/tobacco use, provide coats and shoes to underprivileged children, and 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 kept pace with prior years' attendance levels. Plans already are underway to bring the program back in 2019 during the 86th session of the Texas Legislature. 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 nearly perfect attendance record at TEXPAC board meetings.

Susan Todd, Fort Worth, who chaired First Tuesdays at the Capitol since its inception in 2003, passed the torch to Patty Loose, Austin, last session. Susan Todd was TMAA president in 2002-03, and Patty Loose was TMAA president in 2015-16. Both have been active in TMA's legislative and political activities for many years.

TMA Foundation

The alliance continues its involvement and promotion of the TMA Foundation by assisting with the annual benefit and TMAF's ongoing efforts to heighten awareness of the foundation and its value to TMA and the alliance. The official family holiday sharing card was repeated in 2017, raising more than $3,000, which exceeded the 2016 amount. County alliances also contribute manpower, funds, and raffle items to support the annual benefit event during TexMed and will help TMAF celebrate its 25th anniversary in May in San Antonio.

Alliance members serving on the TMAF Board of Trustees are Angela Donahue, Patrick Hearn, and D'Anna Wick.

Staff News

After nearly 30 years of service to the alliance, Executive Director Loretto Koepsel retired in March. Judy Julian, a 25-year TMA veteran, has been named interim director.

TMAA Centennial Celebration 2018

The alliance will celebrate 100 years of service to medicine and the Family of Medicine during TexMed 2018 in San Antonio. A steering committee composed of past and current alliance leaders across Texas has been busy planning for an exciting celebration to acknowledge this important milestone. The evening event will be on Thursday, May 17, at the JW Marriott Resort in San Antonio. Marcia Ball, Texas Musician of the Year for 2018, will be the featured entertainer. Karen Lairmore, Belton, will preside over the festivities as the 100th TMA Alliance president.

REPORT OF TMF HEALTH QUALITY INSTITUTE

TMFHQI Report 1-A-18

Subject: TMF Health Quality Institute Annual Report

Presented by: Steven L. Gates, DO, Chair

TMF Health Quality Institute has worked with Texas physicians for more than 46 years to help improve the health of Texans and health care in our communities.

TMF is recognized for our expertise and successes in delivering measurable improvements in the quality and delivery of health care, which derives from the strength of our relationship with Texas physicians.

As the Centers for Medicare & Medicaid Services (CMS) Quality Innovation Network Quality Improvement Organization (QIN-QIO) for Texas, Arkansas, Missouri, Oklahoma, and Puerto Rico, TMF is contracted to conduct various health care initiatives. These initiatives include improving cardiac health, reducing disparities in diabetes care, increasing screening and awareness of chronic kidney disease, improving rapid recognition and proper self-management of chronic obstructive pulmonary disease (COPD) exacerbation thereby reducing COPD emergency department utilization and subsequent inpatient hospital admissions, improving prevention efforts through meaningful use of health information technology, reducing harm in nursing homes, enhancing the coordination of care for patients to reduce unnecessary hospital readmissions, improving drug safety practices, promoting appropriate use of antimicrobials (including antibiotics), ensuring that eligible clinicians can easily comply with Merit-based Incentive Payment System (MIPS) requirements and smoothly transition into Alternative Payment Models, assisting providers with quality reporting, improving immunization rates, increasing screening of depression and alcohol use disorders and supporting the Transforming Clinical Practice Initiative.

Our QIN-QIO contract also provides new guidance on patient and family engagement in the patient's health care. Through classes and various other outreach efforts, TMF is empowering patients and their family caregivers to be more confident participants in their health care. They are encouraged to be more open, informative, and helpful to their physicians to get the best care and to be more inquisitive about the self-management of their health.

In our ongoing efforts to engage patients, caregivers, physicians, health care providers, advocates and other stakeholders in a collaborative community, TMF continues to enhance our online Learning and Action Networks, which now include more than 16,500 U.S. and international users. These networks provide a forum for positive interaction, learning, sharing of resources and best practices.

TMF is helping to improve health care in our communities through a variety of other state and federal contracts. We are increasing vaccines for children across Texas, training community health workers on chronic disease, and providing various health care facilities with data to help them self-audit to stay in compliance with Medicare regulations. Since TMF began working to promote childhood immunizations more than 10 years ago, we have successfully managed and completed more than 37,000 provider site reviews in multiple states. Through the CMS Civil Money Penalty (CMP) Reinvestment Program, TMF is collaborating with others to help drive large-scale national improvements in quality of care and life across skilled nursing facilities. Separately, TMF has been awarded a CMP contract to improve oral hygiene for nursing home patients in Texas and Oklahoma.

TMF also is providing support for small medical practices in the CMS Quality Payment Program. Through this program, TMF provides Texas practices with technical assistance and services. This technical assistance brings direct support to thousands of MIPS-eligible clinicians in small practices with 15 or fewer clinicians, including small practices in rural locations, Health Professional Shortage Areas, and Medically Underserved Areas. The direct technical assistance is free to all MIPS-eligible clinicians and delivers support for up to a five-year period. TMF also is supporting physicians who are part of this program in Arkansas, Colorado, Kansas, Louisiana, Mississippi, Missouri, Oklahoma, and Puerto Rico.

We are honored to be partnered with the Texas Medical Association and the Texas Osteopathic Medical Association (TOMA) in offering the Texas Physician Practice Quality Improvement Award Program. The awards recognize Texas practices for their dedication and commitment to providing high-quality patient care. Please visit TMF's website, www.tmf.org, for information about eligibility for and criteria of this noncompetitive recognition program. We are grateful to TMA and TOMA for their foresight in setting up TMF Health Quality Institute. Together, we are in the best position to help Texas physicians and their patients realize outstanding health care in an ever-changing health care environment.

Revised for Supplement
Items in Supplement are in italics.
Distributed at Meeting

AGENDA
REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS
Friday, May 18, 2018
JW Marriott San Antonio Hill Country Resort, Level 2, Cibolo Ballroom 6

1. *Speakers' Report 1 – Transparency in Election in the House of Delegates (Resolution 109-A-17)*

2. Speakers' Report 2 – Election of TMA Board of Trustees Members, Filling Vacancies by Special Election (Resolution 101-A-17)

3. Council on Constitution and Bylaws Report 2 – Election of TMA Board of Trustees Members, Filling Vacancies by Special Election (Resolution 101-A-17)

4. *Board of Trustees Report 12 – Sunset Review of TMA Standing Committees*

5. Board of Trustees Report 13 – Policy Review

6. Board of Trustees Report 14 – TMA 2025

7. Board of Trustees Report 15 – Amendments to Constitution and Bylaws Chapter 9, Councils

8. Board of Councilors Report 4 – Support of Evidence-Based Medicine (Resolution 107-A-17)

9. Board of Councilors Report 5 – Emeritus Nomination

10. Board of Councilors Report 6 – Honorary Nominations

11. Board of Councilors Report 7 – Policy Review

12. Texas Delegation to the AMA Report 3 – Texas Delegation Operating Procedure Changes

13. Medical Student Section Report 1 – Medical Student Section Operating Procedures Update

14. Young Physician Section Report 1 – Young Physician Section Operating Procedures Update

15. Council on Constitution and Bylaws Report 1 – Amendments to the TMA Constitution

16. Council on Science and Public Health Report 1 – Rejection of Discrimination (Resolution 304-A-17)

17. Patient-Physician Advocacy Committee Report 2 – Review of Policy 265.019 Disruptive Behavior Standard

18. Resolution 101 – Patient-Centered Medical Record Responsibilities (Webb-Zapata-Jim Hogg County Medical Society)

19. Resolution 103 – Internet-Based Notification of Patients When a Physician is Closing or Leaving a Practice (Travis County Medical Society)

20. Resolution 104 – Clarification of Guidelines for Online Prescribers in Texas (Travis County Medical Society)

21. *Resolution 105 – Revision of Section 165.155 (a) of the Texas Occupations Code, Solicitation of Patients (Bexar County Medical Society)*

22. Resolution 106 – Creation of a TMA Ad Hoc Committee on the Power and Influence of the Texas Non-Profit Health Corporation (NPHC)/501A Organization (Bexar County Medical Society)

23. Resolution 107 – Physician Protections When Reporting Violations of Non-profit Health Corporations (Harris County Medical Society)

24. Resolution 108 – Inclusion of Medical Students in Good Samaritan Laws and Policies for Disaster Settings (Medical Student Section)

25. Resolution 109 – Liability Exemptions for Volunteer Medical Health Workers (Harris County Medical Society)

Notes*:*
Resolution 102 was withdrawn by the author; and
Resolution 110 is now referred to the Reference Committee on Socioeconomics and is renumbered Resolution 407.

Revised

REPORT OF SPEAKERS

SPKR Report 1-A-18

Subject: Transparency in Election in the House of Delegates (Resolution 109-A-17)

Presented by: Susan M. Strate, MD, Speaker

Referred to: Reference Committee on Financial and Organizational Affairs

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Resolution 109-A-17, Transparency in Election in the House of Delegates, from the Angelina County Medical Society, was referred to the TMA speakers with a report back to the House of Delegates at A-18. The resolution requests that:

(1) 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

(2) 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.

Your speaker notes that individual house members already maintain the right to review all house election results. These results are available to any TMA member upon request on site after elections conclude, or following adjournment of the meeting by contacting TMA House of Delegates staff. However, members may not always be aware of this option. It is likely that members would benefit from efforts to increase clarity and transparency regarding TMA's balloting procedures and availability of voting results.

Announcing vote counts publicly could lead to considerable disruption in house proceedings. Prolonged discussions among house members regarding the counts and increased calls for vote confirmations are likely to occur, thereby impeding the business schedule and potentially fostering a contentious atmosphere. Members may feel undue concern when encountering a tight election, not having been accustomed with the reality that votes are sometimes exceedingly close, yet still valid. What's more, candidates themselves may not wish to have vote counts publicly displayed, and caucus members may feel that announcing the counts limits their ability to vote independently.

To increase awareness of current TMA election protocols, the TMA speakers of the house can provide members with a TMA Balloting Procedures resource document. Members also will continue to have access to specific election results. For these reasons, the TMA speakers recommend the following amendments to Resolution 109-A-17:

Recommendation 1: 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;~~ a TMA Balloting Procedures resource document be posted on the TMA website and distributed at each annual session; and

Recommendation 2: Final vote counts of all secret ballots in the TMA House of Delegates continue to be made ~~public and made part of the official proceedings of the house.~~ available to any member upon request on site after elections conclude, or following adjournment of the meeting by contacting the TMA House of Delegates staff.

Recommendation 3: That Resolution 109-A-17 be adopted as amended.

REPORT OF SPEAKERS

SPKR Report 2-A-18

Subject: Election of TMA Board of Trustees Members, Filling Vacancies by Special Election (Resolution 101-A-17)

Presented by: Susan M. Strate, MD, Speaker, TMA House of Delegates

Referred to: Reference Committee on Financial and Organizational Affairs

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Resolution 101-A-17 was referred to the TMA speakers of the house and Council on Constitution and Bylaws. The resolution, Election of TMA Board of Trustees Members, Filling Vacancies by Special Election, asks that: (1) 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; (2) TMA Bylaws, Chapter 4, Board of Trustees, Section 4.40, Term, tenure, and vacancies of at-large positions, be amended; and (3) TMA Bylaws, Chapter 7, Elections, Section 7.42, Balloting, Subsections 7.421, First Ballot, and 7.422, Run-off ballot, be amended.

The speakers consulted with caucus leaders at the 2017 Fall Conference and 2018 Winter Conference meetings of the Speakers' Advisory Committee concerning the changes sought by Resolution 101. During these meetings, the chair of the Council on Constitution and Bylaws provided information and updates on the council's efforts to examine the points raised within the resolution. Their research included a review of the Board of Trustees election process, balloting measures, term length, and total lifetime of service.

Using the research findings, the council and the speakers, in consultation with caucus leaders, agreed upon a proposed solution for the concerns outlined within Resolution 101, to include the following elements:

- Assurance that Board of Trustees members serving on the board prior to the 2018 TMA elections will remain unaffected by bylaw amendments relating to board terms and tenure limits.
- Elimination of unexpired terms to allow candidates elected as at-large members of the board to receive three-year terms whether the vacancy was scheduled or unscheduled. Thus, new board candidates will know the term length in advance of the campaign and election.
- Reduction in the total lifetime of service on the Board of Trustees from 10 years to nine years to ensure a dynamic election process. This change will provide regular turnover and even greater opportunities for physician members to elevate within TMA leadership.
- Amendment of the TMA Election Process to remove the reference to varying term lengths on the board.

Therefore, in addition to the TMA Bylaws amendments recommended in CCB Report 2-A-18, the following recommendations are offered in lieu of Resolution 101-A-17:

Recommendation 1: That each at-large and ex-officio member of the TMA Board of Trustees elected prior to TexMed 2018 continue to abide by the term of office and length of tenure provisions specified in the TMA Bylaws at the time the member first was elected to the board, regardless of future amendments to these bylaws provisions.

Recommendation 2: Amendment of TMA Policy 295.013 Election Process, as follows:

295.013 **Election Process:** The Texas Medical Association recognizes the following election process:

The Texas Medical Association House of Delegates ~~(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, the nine at-large members and the young physician member of the Board of Trustees, a councilor for each district, and delegates and alternate delegates to the ~~AMA~~ American Medical Association. The house confirms district elections of vice councilors.

Nominations

Members of the house and county medical societies receive advance information on elective positions to be filled at the next annual session and the protocol for nominations. Candidates and/or those who will nominate candidates will notify ~~HOD~~ House of Delegates staff at TMA headquarters as soon as possible so that the names of candidates seeking election or reelection can be distributed to members of the house and county medical societies.

Nominations are 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 complete the required candidate information as stated in the TMA Election Process. Candidates are encouraged to complete this information in advance and send it to ~~HOD~~ House of Delegates staff at TMA headquarters at least one week before the opening session of the meeting at which the election is to be held. Candidates nominated from the floor will complete the requisite information on site and provide the information as soon as practicable to be distributed to the house prior to the election.

Guidelines

The intent of the following guidelines is to encourage fair, open, and equitable campaigning by: (1) specifying permitted and prohibited election related activities, (2) fostering opportunities for candidates to educate their colleagues about the issues, (3) informing voters about candidate experiences and views, (4) keeping costs down, and (5) maintaining dignified and courteous conduct appropriate to the image of the medical profession. The TMA Election Process with campaign guidelines is posted on the TMA website at 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 should send a candidate announcement to house members by email or U.S. ~~M~~mail before annual session rather than distribute announcement cards to delegate seats at the meetings. Candidates may make personal phone calls and send letters. Including the initial announcement and one follow up, a maximum of two mass communications (an impersonal, one-way email or mail communication to all or part of the house membership, sponsored by or on behalf of a candidate) may be used for campaign purposes.

Candidates may make use of personal websites, blogs, social media, videos, ~~etc~~ and the like. 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.

Candidates may display one 24"x36" poster in the Credentials Committee area at the entrance to the ~~HOD~~House of Delegates meeting; TMA provides easels. Candidates may not distribute any other campaign materials at the meeting.

Candidates will provide information as requested by the speakers including a candidate profile form. TMA publishes candidate information in the *Handbook for Delegates* and on the TMA website, eliminating the need for campaign literature. TMA will send an announcement indicating where house members can find candidate information.
Any candidate for at-large trustee or any office that includes an ex officio seat on the TMA Board of Trustees (president, president-elect, secretary/treasurer, and speaker and vice speaker of the House of Delegates) shall provide full disclosure of affiliations on a form developed by the speaker of the house by the time of the election.

TMA will host a forum for candidates at the annual session. Candidates for TMA office should not attend meetings of county medical societies unless officially invited.

Candidates may accept reimbursement of travel expenses by the county society in accordance with the policies of the society.

Compliance
Each candidate is provided a copy of these guidelines and is expected to abide by them. Candidates are to inform those involved in their campaign efforts about the guidelines by sending a copy or by calling attention to the guidelines in the Election Process posted on the TMA website.

When candidates or their supporters are unclear about whether an intended campaign action is permitted, before taking action, they should seek the opinion of the speaker of the House of Delegates by contacting ~~HOD~~house staff at TMA ~~H~~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 are by secret ballot and a majority of the votes cast are necessary to elect. When there are three or more nominees for a single position, the candidate receiving the least number of votes on each ballot shall be dropped until one of the said nominees receives a majority vote. When there is only one nomination, vote may be by acclamation.

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, elected candidates assume office at the adjournment of the ~~HOD~~House of Delegates meeting at the annual session. AMA delegates and alternate delegates assume office on Jan~~uary~~. 1 of the year following their election except those who are elected to fill vacancies, in which case they assume office at the adjournment of the annual session (SPKR Rep. 1-A-12; amended SPKR Rep. 1-A-17).

Revised

REPORT OF BOARD OF TRUSTEES

BOT Report 12-A-18

Subject: Sunset Review of TMA Standing Committees

Presented by: David N. Henkes, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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TMA Bylaws provide that standing committees of the association shall be discharged at the expiration of three years unless the parent council or board petitions the Board of Trustees. The House of Delegates then acts on the recommendations of the board.

At the 2016 Winter Conference, the Board of Trustees (BOT) approved a report detailing the findings and recommendations of a BOT Task Force on TMA Committee Sunset Review Process. The task force's report was in response to Resolution 106-A-15, TMA Sunset Review of Councils, Committees, and Sections, referred to the board for study.

Upon review and deliberation of the issues raised in Resolution 106-A-15, the board discerned the need for greater collaboration of all parties involved in and affected by sunset recommendations. The board further recognized the importance of transparency of criteria and inclusive communication of process prior to sunset recommendations coming before the House of Delegates. The BOT task force report contained five recommendations:

1. That, as part of their appointment, council and committee members be provided with annual objectives and goals and how they align with TMA's overall strategic efforts.
2. That criteria for sunset review align with TMA strategic goals and objectives and that the criteria be communicated to councils and committees in a transparent and efficient manner at the beginning of each year with ongoing collaboration with the Board of Trustees as the year progresses.
3. That sunset review be accomplished as reasonably and efficiently as possible and that for any major change (discharge, reorganization), the Board of Trustees actively participate and collaborate with all affected councils or committees and, if necessary, seek external member input prior to forwarding recommendations to the House of Delegates.
4. That TMA provide (1) an orientation of council and committee chairs as to their roles and the association's organizational structure; and (2) a mechanism for better communication between council chairs and the Board of Trustees and between council chairs with each other.
5. That the Council on Constitution and Bylaws be asked to consider issues identified in this report in light of options for alternatives to standing committees such as use of subcommittees to allow organizational effectiveness and efficiency.

TMA's Council on Constitution and Bylaws Report 1-A-17 found that, as a supplement to TMA Bylaws, parliamentary procedure provides a good deal of direction concerning the functions of committees, subcommittees, and special groups. The council recommended adoption of the new *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* (AIP) to ensure TMA is following the most up-to-date parliamentary procedures (SPKR and CCB Joint Report 1-A-17, Adopted A-17).

In further response to these recommendations, an orientation video has been created and will be shared with all council and committee members and posted to the TMA website. It clearly describes the functions and work products expected of TMA councils and committees, as well as other general requirements including attendance. This video will discuss the TMA governance process, and the process of committee sunset review. The board also approved the use of a simple, one-page form for use by all councils to evaluate standing committees reporting to them.

Board of Trustees
The Interspecialty Society Committee provides its member societies and other specialty societies an entity to which legislative, social, economic, and professional concerns may be presented and transmitted to the House of Delegates or other appropriate bodies of the association. The committee has been recognized as the conduit for specialty concerns and offers specialty societies a voice within TMA.

The Committee on Membership provides physician-led guidance in the development of annual and long-term membership recruitment and retention programs. County society staff serve as consultants to the committee. The committee is instrumental in providing guidance on proposed marketing strategies, ideas for new and emerging membership segments, removing barriers to membership, a local physician view of TMA policies and procedures, and direction and assistance for local market activities. Its efforts contribute directly to membership recruitment and retention, which continues to increase every year, contributing to an annual dues revenue budget which now stands at $16.55 million, making up 63.3 percent of TMA's overall revenue budget. TMA membership is now 51,532 members strong.

Recommendation 1: Continue the Interspecialty Society Committee and Committee on Membership for three years.

Board of Councilors
The Committee on Physician Health and Wellness reports to the Board of Councilors. The Committee on Physician Health and Wellness (CPHW) has many duties. The duties include promoting healthy lifestyles in Texas physicians, reviewing rehabilitation provided to physicians with potentially impairing conditions, liaising with the Texas Medical Board (TMB) and Texas Physician Health Program (TXPHP), making recommendations to the Council on Legislation when there are needed changes in the laws, and providing education on physician health and wellness topics.

These duties are very important to TMA's 2020 goal of engaging in legislative, regulatory, and legal advocacy to improve the environment in which Texas physicians care for their patients.

These important duties have led to many accomplishments by CPHW over the years, including operation of a statewide drug screening program for physicians, production of numerous programs and brochures to educate physicians about wellness, stress and potentially impairing conditions, management of a Physician Health and Rehabilitation Fund to assist affected physicians, surveillance of activities involving physicians reported for suspected impaired conditions, and liaising with the TMB and TXPHP.

Recommendation 2: Continue the Committee on Physician Health and Wellness for three years.

Council on Medical Education
The Committee on Continuing Education serves a unique role both within and outside of TMA. Not only does the committee develop policy for consideration, but also it conducts research used by others within TMA and in the legislative arena. This research is not conducted by any other group in the state and fills a gap. Furthermore, the committee's work supports a uniform, national system of continuing medical education (CME) accreditation, helping to assure physicians, state legislators, CME providers, and the public that all CME programs are held to the same high standards, and enables Texas physicians to maintain their licenses and board certifications. The committee's work also has gained national recognition; TMA has been asked to provide services to other state medical societies that are struggling with their CME accreditor programs. The council agrees there is sufficient evidence to demonstrate the committee's effectiveness in fulfilling its charge over the past three years; not continuing the committee would have a devastating impact on accredited CME organizations and physicians in Texas.

The Committee on Physician Distribution and Health Care Access serves in a unique role of monitoring and reporting on dominant trends in the physician workforce and in other health professions, and identifying research on the state's workforce needs. Work of the committee has gained national and state

recognition, and the committee fills a gap in state workforce planning. The outcomes assist the Council on Medical Education in formulating policy recommendations on medical education and inform TMA's advocacy activities with both Congress and the Texas Legislature.

Recommendation 3: Continue the Committee on Continuing Education and Committee on Physician Distribution and Health Care Access for three years.

Council on Science and Public Health

Five standing committees report to the Council on Science and Public Health: Committee on Cancer, Committee on Child and Adolescent Health, Committee on Emergency Medical Services and Trauma, Committee on Infectious Diseases, and Committee on Reproductive, Women's, and Perinatal Health. Overall, the council commends each of the committees' activities and accomplishments. Each of the committees met the necessary meeting and attendance requirements. These committees submitted numerous reports to the House of Delegates, created physician education, worked closely with other committees, and advocated on numerous issues.

The Committee on Cancer has been focusing on educating Texas physicians and the public regarding updated information on cancer prevention and treatment. Targeted initiatives such as HPV vaccination and HCC education will have long-term effects on mitigating the risks of cancer on the residents of Texas. Efforts to address tobacco prevention and cessation have been included in CME opportunities, and collaboration with the advocacy efforts through the Texas Public Health Coalition forums.

The Committee on Child and Adolescent Health (CCAH) is an important advocate for pediatrics and child health in Texas. CCAH provides input and expertise regarding public health and its impact on child health. CCAH serves to review, advise, and advocate for legislative issues in Texas that impact child health and pediatrics. CCAH provides resources for TMA on pediatric issues, pediatric providers, immunization practices, and funding for pediatric care. The committee advocates for fragile populations involving children and provides input on the epidemiology of childhood illnesses such as influenza and Respiratory Syncytial Virus.

The Committee on Emergency Medical Services and Trauma's charge is to: (1) work with all parties in the formulation, initiation, and maintenance of community plans for emergency medical services leading to statewide coverage; (2) provide liaison between the Texas medical community and government agencies concerned with emergency medical care; (3) educate and inform Texas physicians on the developments in emergency medical services at national and state levels; (4) identify and review state health programs relating to emergency medical services, injury prevention, and trauma care; (5) participate in, and provide physician input to, these state health programs; (6) maintain liaison with government agencies devoted to preparation and execution of plans in the event of any occurrence of catastrophic proportions, and educate Texas physicians about plans for medical care in disaster situations; (7) study, evaluate, and make recommendations regarding trauma and related problems, including accidents and physical abuse resulting in trauma; and (8) study, evaluate, and make recommendations regarding the development and funding of a statewide trauma system.

The Committee on Infectious Diseases (CID) currently is engaged in a number of activities, working closely with other TMA committee members, Texas Department of State Health Services (DSHS), the Cancer Coalition, Texas Pediatric Society, and frontline providers on ways to improve HPV coverage in Texas. The group has examined ImmTrac functionality, advised on an infographic created by BeWise, explored options for advising providers on vaccine tracking using EHRs, and discussed opportunities to work with additional stakeholders including the Texas Parent Teachers Association and the Texas School Nurses Association. Identifying a deficiency of reliable, validated data on the rate of HPV vaccine uptake in children resulted in formation of an HPV data work group led by TMA's CID chair. The committee has identified a variety of activities to promote awareness of multidrug resistant organisms, including

highlighting issues during the national U.S. Antibiotic Awareness Week. The committee will continue to work with the (DSHS) to identify ways to collaborate to inform and assist physicians.

The committee continues to engage with stakeholders on infection control issues related to long-term care facilities. This includes working to prepare for implementation of CMS rule on vaccination, antimicrobial stewardship, and infection prevention and control, convening additional stakeholders meetings, and identifying opportunities to testify and advocate for statewide policy changes.

The committee continues to track other key infectious disease-related legislative topics. This includes raw milk, especially in light of recent outbreaks. In addition, the committee will review the TMA policy on needle exchange and will identify ways during the interim and legislative session to advocate for reduce HIV and HCV infection.

In addition to the charge given to the Committee on Reproductive, Women's and Perinatal Health (RWPH), the committee works in collaboration with TMA groups, state agencies, and other professional organizations to support priorities of the committee including (1) the Council on Science and Public Health workgroups on Zika and LGBT; (2) Texas Association of Obstetricians and Gynecologists and the Committee on Infectious Diseases on developing communication plans for physicians on CMV; (3) developing a report on evaluation and management of stillbirth; (4) Texas Pediatric Society to address newborn screening payment issues; and (5) Women's Health Advisory Committee. There is RWPH-member involvement in state activities including the Task Force on Maternal Mortality and Morbidity; Texas Collaborative for Healthy Mothers and Babies; Task Force on Domestic Violence; Newborn Screening Advisory Committee; Midwives Advisory Board of the Texas Department of Licensing and Regulation; and the Health and Human Services Commission's Perinatal Advisory Committee. RWPH collaborates with DSHS on work plans developed at the 2017 Maternal Mortality and Morbidity Forum.

Recommendation 4: Continue the Committee on Cancer, Committee on Child and Adolescent Health, Committee on Emergency Medical Services and Trauma, Committee on Infectious Diseases, Committee on Reproductive, Women's, and Perinatal Health for three years.

Council on Socioeconomics

Three standing committees report to the Council on Socioeconomics: Committee on Medical Home and Primary Care, Patient-Physician Advocacy Committee and Committee on Rural Health and the council recommends their continuation. All of these committees' duties are integral to TMA's 2020 goal of engaging in legislative, regulatory, and legal advocacy to improve the environment in which Texas physicians care for their patients. Additionally, they both contribute to TMA's 2020 goal of strengthening physicians' trusted leadership role.

The work of the Committee on Medical Home and Primary Care (CMHPC) has led to many accomplishments including ongoing contribution to content and focus of the annual Texas Primary Care and Health Home Summit. Members of the committee are part of the summit leadership team. CMHPC is currently drafting a report on the state of primary care in Texas similar to "The Primary Solution: Mending Texas' Fractured Health Care System." This report was created by the Primary Care Coalition several years ago to educate lawmakers and the public about the role of primary care in the health care delivery system. The report will focus on examining health care costs, promoting the medical home model, ensuring adequate payments for medical home providers, and what other states are doing to promote the patient-centered medical home. It will be integral to the continued development and modification of TMA regulatory and legislative efforts and TMA policy analysis.

The Committee on Rural Health (CRH) has focused on working with the law firm Kemp Smith to start the formation of a rural coalition that would help draw down USDA and other federal dollars to provide no-cost or low-cost loans to rural physicians and other rural providers. CRH also provides valuable feedback on numerous legislative and regulatory issues relating to rural health in Texas such as

telemedicine (including licensure for out-of-state psychiatrists for telemedicine services), the physician loan repayment program, the rural hospital closure crisis, health disparities in rural areas, and GME funding. Committee members have submitted multiple resolutions throughout the years to the TMA House of Delegates that directly impacted and improved rural physicians' practices. Members of CRH serve as liaisons with other rural health stakeholder groups including the Texas Organization of Rural and Community Hospitals and the State Office of Rural Health.

Recommendation 5: Continue the Committee on Medical Home and Primary Care and the Committee on Rural Health for three years.

The Patient-Physician Advocacy Committee (PPAC) continues to be involved with the Texas Medical Board to learn more about its processes and procedures and to offer input on improvements. 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. The committee also provided input to 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.

PPAC also has reviewed several physician-specific cases over the years that have resulted in amicus briefs being submitted to the courts on behalf of TMA members. In the past few years, PPAC has reviewed several cases dealing with apparent shortcomings of the peer review process and with allegations that the peer review process can be used to hide dubious intentions of others. Recognizing what was becoming a trend and to continue the committee's discussion of the peer review process, PPAC further reviewed several academic works that described what some have termed "sham peer review."

Finally, the committee performed a sunset review of TMA's policy on sham peer review. The committee recommended retaining the policy, but determined that TMA could take on a more active role in fulfilling TMA's commitment against sham peer review as outlined in that policy. Recognizing that the committee alone lacked the resources to adequately evaluate the peer review process to determine whether more could be done to ensure a fair review process, the committee recommended to the Council on Socioeconomics that a task force or ad hoc committee be formed to further evaluate the issue.

In addition, PPAC discussed the committee's purposes and how the committee should move forward. The committee reviewed its purposes as stated in TMA's bylaws and found that the committee's charge does not accurately reflect the committee's recent work and focus. The committee proposes an amended charge to more accurately reflect the committee's work.

Recommendation 6: Amend the charge of the Patient-Physician Advocacy Committee in Section 10.532 of TMA Bylaws as follows:

> The committee shall ~~assess~~ evaluate the quality of medical and health care services in the State of Texas and recommend regulatory, legislative, and legal approaches to assure that the highest standard of quality medical care is available for all Texans. The committee shall assess the environments and circumstances in which physicians practice on both a case-by-case and a global basis to identify and advocate against barriers to a healthy environment for the practice of medicine. The committee shall serve as a source of advice on quality ~~assurance, utilization review, and other~~ ~~quality~~ and medical practice environment issues; develop and recommend policy; establish and maintain liaison with appropriate regulatory agencies and with groups with similar interests; and serve in an advocacy role for physicians and patients on issues related to quality ~~assurance, utilization review, and other forms of review~~ and medical practice environment.

Recommendation 7: Continue the Patient-Physician Advocacy Committee, as amended, for three years.

REPORT OF BOARD OF TRUSTEES

BOT Report 13-A-18

Subject: Policy Review

Presented by: David N. Henkes, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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House of Delegates policies in the association's Policy Compendium are reviewed periodically for relevance and appropriateness. The Board of Trustees was asked to recommend to the House of Delegates retention, amendment, or deletion of the following policies:

Policy 160.016 remains relevant and should be recommended for retention.

160.016 General Antitrust Compliance Principles: Following are General Antitrust Compliance Principles of the Texas Medical Association:

TMA will not become involved in the competitive business decisions of its individual members, nor will it take any action that would tend to restrain competition. TMA is firmly committed to the principle of competition served by the antitrust laws, and good business judgment demands that every effort be made to ensure compliance with all applicable federal and state antitrust laws and trade regulations.

TMA members cannot come to understandings, make agreements, or otherwise concur on positions or activities that in any way tend to raise, lower, or stabilize prices or fees, allocate or divide up markets, or encourage or facilitate boycotts. Individual TMA members must make business decisions on their own and without consultation with their competitors or TMA.

The antitrust laws are complicated and often unclear. If any member on TMA business is concerned about being in a "gray area," the member should consult with TMA. If the conversation among competitors at a TMA meeting turns to antitrust sensitive issues, participants should discontinue the conversation until legal advice is obtained or leave the meeting immediately and request that their absence from the remainder of the meeting be recorded in the minutes.

Discussions of pricing or boycotts as part of TMA-scheduled programs or at TMA-sponsored meetings could implicate and involve TMA in extensive and expensive antitrust challenges and litigation. In addition, the United States Supreme Court has determined that an association can be held liable for statements or actions in antitrust sensitive areas by volunteer leaders who claim to speak for the association, even if they are not authorized to speak in that area. Trustees and officers of TMA must, therefore, make clear whether they are speaking in their official capacity when they address such issues. A speaker making personal remarks outside a TMA setting should clearly state that he or she is speaking for himself or herself, and not on behalf of TMA (BOT Rep. 17-A-08).

To assist TMA staff, officers, trustees, and committee chairs in recognizing situations that may give the appearance of an antitrust concern, the Board of Trustees shall provide to each such person copies of this Antitrust Statement. In addition, TMA's Antitrust Statement shall be

referenced at the start of each meeting where TMA business will be discussed, and this action will be noted in the minutes of the meeting.

Any violation of the antitrust policy will be brought to the attention of the Board of Trustees, and the board will deal with it in a timely and appropriate manner. The Board of Trustees will consult with legal counsel when questions arise as to the manner in which the antitrust laws may apply to the activities of TMA.

Specific Rules of Antitrust Compliance

TMA activities shall not be used for the purpose of bringing about, or attempting to bring about, any understanding or agreement, written or oral, formal or informal, expressed or implied, among competitors with regard to prices or fees, terms or conditions of sale, discounts, territories, or customers. For example, any agreement by competitors to "honor," "protect," or "avoid invading" one another's geographic areas, practice specialties, or patient lists would violate the law.

TMA activities and communications shall not include discussion or actions, for any purpose or in any fashion, of prices or pricing methods or other limitations on either the timing of services or the allocation of territories or markets or customers in any way. For example, TMA members cannot come to understandings, make agreements, or otherwise concur on positions or activities that are directed at fixing prices, fees, or reimbursement levels. Likewise, TMA members cannot make agreements as to whether they will or will not enter into contracts with certain managed care plans. Even if no formal agreements are reached on such matters, discussions of prices, group boycotts, or market allocations followed by parallel conduct in the marketplace can lead to antitrust scrutiny or challenges. Members may, however, consult with each other and freely discuss the scientific and clinical aspects of the practice of medicine.

TMA shall not undertake any activity that involves exchange or collection and dissemination among competitors of any information regarding prices, pricing methods, cost of services or labor, or sales or distribution without first obtaining the advice of legal counsel, when questions arise as to the proper and lawful methods by which these activities may be pursued. For example, caution should be exercised in collecting data on usual and customary fees, managed care payment levels, workforce statistics, and job market opportunities. While the mere collection of data on such matters is permissible if certain conditions are met, antitrust concerns may arise if the data become the basis for collective action.

In general, TMA activities and communications shall not include any discussion or action that may be construed as an unlawful attempt to: (1) raise, lower, or stabilize prices; (2) allocate markets or territories; (3) prevent any person or business entity from gaining access to any market or to any customer for goods or services; (4) prevent or boycott any person or business entity, including managed care organizations or other third-party payers, from obtaining services freely in the market; (5) foster unfair trade practices; (6) assist in monopolization, or attempts to monopolize; or (7) in any way violate applicable federal or state antitrust laws and trade regulations. The actual purpose and intent of TMA's policies and programs are important in this regard. They cannot be aimed at accomplishing anticompetitive objectives.

Antitrust Illustrative Fact Situations

A TMA member is participating in a meeting of a TMA committee regarding issues related to health insurer marketplace conduct. The information presented indicates that a particular insurer is undertaking a contracting practice that will have a generally adverse financial impact on many physician practices. In response to the information presented, the TMA member states and proposes that he will never contract with this insurer and that it is the duty of every

physician in the room to let his or her colleagues know that they should not contract with that insurer, either.

Consistent with TMA policy, the chair, another member of the committee, or staff should discontinue the discussion. If there is any doubt that this discussion is not lawful, TMA legal counsel should be consulted.

A TMA member is participating in a meeting of a TMA council on issues related to health insurer marketplace conduct. The information presented indicates that a particular insurer is undertaking a contracting practice that will have a generally adverse financial impact on many physician practices. In response to the information presented, the TMA member declares to those present that no one should accept less than X percent of Medicare.

Consistent with TMA policy, the chair, another member of the council, or staff should discontinue the discussion. If there is any doubt that this discussion is not lawful, TMA legal counsel should be consulted.

A TMA member is participating in a meeting of a hospital medical staff regarding issues related to patient safety. The information presented leads to the discussion of the care provided by a physician. A competing physician offers to those present his opinion that if other physicians agreed to refrain from offering weekend call coverage to Dr. "X," this doctor likely would be forced to leave the community.

Consistent with TMA policy, the TMA member should request that this line of discussion be discontinued. If the discussion continues, the member should leave the meeting and request that his absence be recorded in the minutes.

A TMA member is participating in a meeting of a TMA council on issues related to competence and patient safety. The information presented leads to the discussion of the care provided to patients by physicians practicing specialty "X." A physician of competing specialty "Y" states that TMA should discipline physicians who refer patients to "X" specialists for this kind of care and that TMA should adopt an official position that physicians of specialty "Y" are the only physicians who should provide the type of service in question. In exchange, TMA should stake out an official position outlining when physicians are permitted to refer to "X" specialists, thus ensuring they have market presence.

Consistent with TMA policy, the council chair, council member, or staff shall discontinue the discussion. If there is doubt as to the lawfulness of this line of discussion, TMA legal counsel should be consulted.

A TMA member is serving on a TMA board. The TMA board has an agenda item before it relating to the rising costs of practicing medicine. While discussing the agenda item, a TMA member decides to comment on the failure of payment rates to keep pace with the rising costs of practicing medicine. To address this issue, he further decides to share the prices he has been offered under a particular contract and asks that his fellow TMA members do the same in order to jointly determine a fair contract rate before signing a contract with that payer. Additionally, he suggests that after determining such a rate, members should sign a pledge stating their willingness to accept only rates that comply with the jointly-determined reasonable rate.

Consistent with TMA policy, the board chair, board member, or staff shall discontinue the discussion. If there is doubt as to the lawfulness of this line of discussion, TMA legal counsel should be consulted.

A TMA member is participating in a meeting of a TMA committee regarding issues relating to the scope of practice of nonphysician health care providers. The information provided indicates that a particular class of licensed nonphysician health care providers is seeking a change in its scope of practice to match certain activities currently being offered to patients in Texas. In response, the TMA member states and proposes that TMA members be advised not to refer patients to this class of health care provider and that such action should be publicized through Texas Medicine, TMA Action, and press releases.

Consistent with TMA policy, the committee chair, member, or staff shall discontinue the discussion. If there is doubt as to the lawfulness of this line of discussion, TMA legal counsel should be consulted (BOT Report 17-A-08).

Recommendation 1: Retain

The board recommends an editorial change to Policy 75.003.

75.003 County Medical Societies and Medical Alliances: The Texas Medical Association encourages closer working relationships between county medical societies and ~~their partners,~~ county medical society alliances (TMA Alliance, p 146, I-97; Amended BOT Rep. 13-A-08).

Recommendation 2: Retain as amended.

REPORT OF BOARD OF TRUSTEES

BOT Report 14-A-18

Subject: TMA 2025

Presented by: David N. Henkes, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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In September 2017, the Board of Trustees held a strategic planning meeting with council chairs, Committee on Membership chair, county medical society leaders and executive staff to discuss the current practices of medicine and what could/should be improved. The meeting was also used to identify and define the ideal practices of medicine. Planning sessions of the board take into account a full-spectrum environmental analysis.

More focus is required in order to prioritize how TMA can best address key issues that will most impact Texas physicians, in the midst of consolidation of physician groups and health systems, transformation to value-based care in both the public and private sector is key to the success of the association. The board identified and focused on four issues:

- Membership: Including market consolidation and employment, needs of various demographics
- Practice Viability and Practice Management: regulatory and administrative (mostly payer) burdens, MACRA/MIPS, Medicaid, health information technology
- Population Health: public health preparedness, prevention, women's health
- Physician Workforce and Access to Care: medical education, physician shortage, telemedicine

The result of this planning meeting are proposed changes to TMA's strategic plan made primarily to strengthen, clarify, and remove redundancies. At the planning meeting, a fifth objective was proposed: "access to care for all Texans." This concept has been incorporated as a new objective within the Healthy Environment goal.

Staff teams are still working to compile and refine strategies and tactics under each goal and objective. This level of detail will be placed on council, committee, section, and board agendas during the 2018 Winter Conference in January.

Recommendation: Approve TMA’s 2025 strategic plan.

TMA 2025

Vision **To improve the health of all Texans**

Mission **TMA stands up for Texas physicians by providing distinctive solutions to the challenges they encounter in the care of patients.**

Goal – Practice Strength: Protect and strengthen medical practices in Texas.

Objectives
a. Ensure that Texas physicians receive timely and equitable payment for services rendered.
b. Provide cost-effective solutions to improve all aspects of practice management operations.
c. Promote effective use of technology that supports practice efficiency, quality of care, and management of population health.

Goal – Healthy Environment: Engage in legislative, regulatory, and legal advocacy to improve the environment in which Texas physicians care for their patients.

Objectives
a. Implement public and private sector strategies that promote sustainable health care financing and delivery systems.
b. Advance patient-centered, cost-efficient, physician-directed systems of care.
c. Support a Texas-specific strategy to address growing demand for health care services.
d. Promote access to health care for all Texans.

Goal – Trusted Leader: Strengthen physicians' trusted leadership role.

Objectives
a. Enhance the public image of Texas physicians.
b. Actively pursue evidence-based population health initiatives that improve the health of Texans.
c. Reinforce the physician's role as the leader of the health care team.
d. Advance physician professionalism.

Goal – One Voice: Enhance the powerful, effective, and unified voice of Texas medicine

Objectives
a. Increase membership and member involvement to ensure the ongoing financial health and governance strength of the association.
b. Leverage the effective voice of Texas medicine.
c. Demonstrate a unified voice by strengthening relationships and strategic alliances.

REPORT OF BOARD OF TRUSTEES

BOT Report 15-A-18

Subject: Amendments to Constitution and Bylaws Chapter 9, Councils

Presented by: David N. Henkes, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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Each year, the current Texas Medical Association president-elect is given an opportunity to make appointments to TMA's councils and committees. While there typically are between 30 and 35 vacancies on all association councils and committees, there are more than 100 appointment recommendations. Some councils draw more interest than others, including the Council on Legislation, Council on Socioeconomics, Council on Medical Education, and Council on Science and Public Health.

In 2000, TMA made an effort to increase opportunities for TMA members to serve on councils and committees by reducing the allowed number of three-year council and committee terms from three terms to two terms. Although this has helped, more needs to be done.

In 2010, the Board of Trustees recommended, and the House of Delegates approved, increasing the cap on council membership from 12 to 15 members. Since that time, membership in TMA has increased by 14.3 percent with no notable changes to the number of members of councils and committees.

The TMA Leadership College also was established in 2010, bringing young physicians into a training process for TMA leadership roles. At TexMed 2018, 23 scholars will graduate from the program, with a total alumni of 138; yet, relatively few have opportunities to contribute back to the association.

TMA Bylaws provide that councils shall have nine to 15 members. Councils engage on a breadth of issues and there continues to be a need for more geographic and specialty diversity. Expanding council membership would increase opportunities for physician member participation and allow for greater diversity.

Your Board of Trustees takes this opportunity to propose a bylaws amendment so all councils may be permitted to have up to 18 members.

Recommendation: Amend Chapter 9, Councils, Section 9.31, as follows:

9.31 Number of members. Councils may consist of nine to ~~15~~ 18 members.

Fiscal note: $16,400

REPORT OF BOARD OF COUNCILORS

BOC Report 4-A-18

Subject: Support of Evidence-Based Medicine (Resolution 107-A-17)

Presented by: Charles M. Perricone, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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Background

At TexMed 2017, the Medical Student Section filed Resolution 107 relating to support of evidence-based medicine. The resolution states, among other things, that (1) 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 (2) 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.

The resolution resolves that (1) TMA adopt policy opposing the criminalization of evidence-based medical care, (2) TMA policy also oppose the revocation of a medical license for the provision of evidence-based medical care, and (3) TMA encourage TEXPAC to consider previous and planned actions to criminalize the practice of medicine when deciding endorsements and allocation of funds.

The House of Delegates assigned the resolution to the Reference Committee on Financial and Organizational Affairs. The reference committee heard testimony that generally supported the intent but expressed concerns regarding the TEXPAC directive and unintended consequences for the association if adopted in its current form. The resolution ultimately was referred and later assigned to the TMA Board of Councilors.

Discussion

TMA has existing policy addressing evidence-based medicine and the importance of physicians maintaining autonomous clinical decisionmaking authority.

The Board of Councilors reviewed and discussed the resolution and accompanying documents. The Board of Councilors noted that TMA already has policy advocating "the use of the most current, best clinical research evidence in all determinations and assessments of appropriate medical care."

TMA, through the Council on Legislation, already opposes the criminalization of evidence-based medical care and revocation of a medical license for the provision of evidence-based medical care. Examples from the 85th legislative session include bills related to ophthalmia neonatorum and do-not-resuscitate orders.

Conclusion

The Board of Councilors discussed the importance of evidence-based medicine and considered existing TMA policy and practice and recommends the following:

Recommendation: That the House of Delegates not adopt Resolution 107-A-17.

Related 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.

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.

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).

REPORT OF BOARD OF COUNCILORS

BOC Report 5-A-18

Subject: Emeritus Nomination

Presented by: Charles M. Perricone, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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The TMA House of Delegates, upon nomination by the county medical society in which the member belongs and approval by the TMA Board of Councilors, may elect a member of the association who has rendered exceptional and distinguished service to scientific or organized medicine, or both, to the status of member emeritus.

The Board of Councilors has approved the nomination of Nalin H. Tolia, MD, for emeritus membership and recommends his election by the House of Delegates. A brief sketch follows for Dr. Tolia.

Nalin H. Tolia, MD (Ector County Medical Society)
Dr. Tolia received his master of surgery in ophthalmology in 1969 from the University of Bombay (now the University of Mumbai), Seth G.S. Medical College, in Mumbai, India. He has been a member of TMA and Ector County Medical Society (ECMS) for 43 years.

Dr. Tolia served as ECMS president in 1989 and 2001 and has served as a delegate to the TMA House of Delegates for the past 25 years. He also has served on the Board of Trustees and Advisory Council of the Texas Medical Association Foundation. Dr. Tolia served as both the chair and a member of the governing board of the TMA International Medical Graduate Section.

Dr. Tolia has served as president of the Association of Indian Physicians of Texas, the Texas Indo American Physicians Society, and the American Association of Indian Ophthalmologists.

Dr. Tolia has served as a member of the Board of Trustees for the Texas School for the Blind and Visually Impaired and the Texas State Board of Medical Examiners District Three Review Committee.

Additionally, Dr. Tolia has received multiple awards, including the Heritage of Odessa Foundation Community Statesman Award for Health and Science, the “R.C. Hoyles” award for community service, and the Samaritan Counseling Center’s Family of the Year Award.

Recommendation: Election of Dr. Tolia to emeritus membership in the Texas Medical Association.

REPORT OF BOARD OF COUNCILORS

BOC Report 6-A-18

Subject: Honorary Nominations

Presented by: Charles M. Perricone, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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The TMA Board of Councilors has approved the nominations of William J. Deaton, MD; John D. McKeever, MD; and William A. Walker, MD, for honorary membership and recommends their election by the TMA House of Delegates. A brief sketch follows for each member.

William J. Deaton, MD (Travis County Medical Society)
Dr. Deaton received his medical degree from Baylor College of Medicine. He has been a member of TMA for 43 years.

He has served Travis County Medical Society (TCMS) as a delegate and on the Executive Board, Membership Committee, Strategic Planning Committee, and Board of Ethics.

John D. McKeever, MD (Nueces County Medical Society)
Dr. McKeever received his medical degree from Jefferson Medical College of Thomas Jefferson University. He has been a member of TMA and Nueces County Medical Society for 45 years.

He has served Nueces County Medical Society as president and vice president, on the Board of Censors and Council on Legislation, and as a TMA delegate.

William A. Walker, MD (Travis County Medical Society)
Dr. Walker received his medical degree from The University of Texas Southwestern Medical School in Galveston in 1959. He has been a member of TMA and Travis County Medical Society for 55 years.

He has served TCMS on the Mediation Committee, the Board of Censors, the Blood Center of Central Texas Board, and the Central Texas Medical Foundation Board.

Dr. Walker served as TCMS president in 1988.

Recommendation: Election of Drs. Deaton, McKeever, and Walker to honorary membership in the Texas Medical Association.

REPORT OF BOARD OF COUNCILORS

BOC Report 7-A-18

Subject: Policy Review

Presented by: Charles M. Perricone, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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TMA periodically reviews House of Delegates policies in the association's Policy Compendium for relevance and appropriateness. The TMA Board of Councilors' recommendations for retention or deletion of the following policies are summarized in this report.

The Board of Councilors recommends retention of the following policy:

85.010 **Terminally Ill**: Only one physician should be required to certify that a patient is terminally ill under the Texas Advance Directives Act rather than certification by two physicians (BOC Rep. 8-I-98; amended BOC Rep. 7-A-08).

Recommendation 1: Retain.

The Board of Councilors recommends deletion of the following 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).

Recommendation 2: Delete.

REPORT OF TEXAS DELEGATION TO THE AMA

TEXDEL Report 3-A-18

Subject: Texas Delegation Operating Procedure Changes

Presented by: David N. Henkes, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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Changes to the Operating Procedures of the Texas Delegation's Policy and Procedures Manual requires approval from the House of Delegates.

Section 3.0 addresses officers and elected positions. The procedures currently designate the two vice chairs of the delegation as Places 1 and 2. At the 2018 annual election of delegation officers, members of the delegation expressed the assumption that, when the chair position is vacant, the Place 1 vice chair would automatically assume the position of chair. The delegation would like to make it clear that both vice chair positions are equal.

The delegation recommends the following amendments to its Operating Procedures:

3.0 Officers and Elected Positions

3.1 The officers of the delegation shall be a chair and two vice chairs. Only delegates shall be eligible to serve as chair and ~~vice chair, Place 1.~~ one vice chair. Delegates and alternate delegates shall be eligible for election to one vice chair position.~~, Place 2~~. The term of officers shall be one year, but they may be elected to subsequent terms; the maximum number of terms for chair shall be 10, subject to available tenure as a delegate.

3.2 Two members-at-large shall be elected to the Delegate Review Committee. Both delegates and alternate delegates shall be eligible for election. The term of the members-at-large shall be one year, but they may be elected to subsequent terms.

Recommendation: Approve changes to Section 3.0 of the Texas Delegation's Operating Procedures.

REPORT OF MEDICAL STUDENT SECTION

MSS Report 1-A-18

Subject: Medical Student Section Operating Procedures Update

Presented by: Jennifer Nordhauser, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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In 2017, the Texas Medical Association Medical Student Section (TMA-MSS) initiated a review and update of the section's operating procedures. The MSS Operating Procedures manual provides information and guidance regarding policies and protocols for the section, additional to the relevant provisions of the TMA Constitution and Bylaws. Upon review, the section identified necessary updates to more adequately describe the composition of the MSS leadership, better accommodate the addition of new medical schools to section membership, and omit extraneous portions of the procedures. This report details the amendments to the MSS Operating Procedures recommended by the section for approval by the House of Delegates.

Recommendation: Amendment of TMA Medical Student Section Operating Procedures, as follows:

TEXAS MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION OPERATING PROCEDURES

1.10 NAME. The name of the organization shall be the Medical Student Section (MSS) of the Texas Medical Association.

2.10 PURPOSES. The purposes of the Medical Student Section are to (1) participate in the shaping of the future of medicine in Texas by active involvement in the affairs of the various Texas county medical societies, the Texas Medical Association, and the American Medical Association; (2) foster dialogue between individuals and organizations within medicine; (3) promote and aid in programs which may serve to unify and give direction to health-related activities at all levels of education; and (4) provide a good and useful service to the medical students in Texas.

3.10 ORGANIZATION AND VOTING PRIVILEGES. The section shall be comprised of medical students who are members in good standing of the Texas Medical Association by virtue of being dual members of component county medical societies and medical school chapters. The student must be presently attending full-time a medical school in Texas recognized by the ~~Texas State Board of Medical Examiners~~ Texas Medical Board in a field of study leading to a degree of Doctor of Medicine or Doctor of Osteopathy, except as provided in Section 10.10.

Any student member in good standing of the section may address the section, participate in debate within the section, and submit resolutions for consideration by the section.

~~Voting representatives to the section shall be voting members of the MSS Executive Council and those chapter representatives officially selected by the association's student members at each individual medical school chapter as stated in Section 9.16 of these procedures. Only voting representatives shall have the right to vote on business of the section including elections for positions on the Executive Council.~~

Items of business considered by the section are voted on by its constituent medical school chapters, as defined in 9.10. Each year, an official census of each chapter's membership shall be taken on April 1 preceding the association's annual meeting. Each chapter shall be entitled to representation according to the following formula: schools with 100 members or less are allowed two votes; those with 101 to 200 members are allowed four votes; those with 201 to 400 members are allowed five votes; those with 401 to 600 members are allowed six votes; and those with more than 600 members are allowed seven votes.

4.10 MEETINGS. The section shall have the authority to meet as often as deemed appropriate, but at least twice annually~~, meeting once at the time of the association's annual session and once at the time of the winter conference~~. A quorum for the conduct of business at a section meeting ~~shall consist of a majority of chapter representatives to the section, provided that at least five of the eight medical schools are represented~~ is achieved upon meeting both of the following conditions: (1) the number of active medical school chapters that are present and voting is greater than 50 percent of the total number of active chapters within the MSS; and (2) the chapters that are present and voting control greater than 50 percent of the total number of votes allotted to all chapters in Section 3.10.

5.10 EXECUTIVE COUNCIL.

5.11 Composition. The section's chair, vice chair, reporter, ~~and the two TMA delegate co-leaders~~ two TMA delegation co-chairs, two AMA delegation co-chairs, the student serving as a special appointee to the TMA Board of Trustees, and the student serving as an alternate delegate on the Texas Delegation to the AMA shall serve as voting members of the Executive Council. The immediate past chair will be a non-voting member.~~ two AMA delegate co-leaders, the student serving as a special appointee to the TMA Board of Trustees, and the student serving as an alternate delegate on the Texas Delegation to the AMA~~. Members of the section who are elected to the AMA-MSS Governing Council ~~national office~~ also may serve as non-voting consultants at the discretion of the voting members of the council.

5.12 Duties and term. The chair shall be the principal officer of the section and shall preside over all meetings of the section and Executive Council. The vice chair shall assist the chair in the performance of the chair's duties and shall serve as parliamentarian of the section. The reporter shall record the minutes of all meetings of the section and Executive Council. The ~~TMA delegate co-leaders~~ TMA delegation co-chairs shall represent ~~section delegates and alternate delegates elected by chapters~~ chapter delegates and alternate delegates to the TMA House of Delegates at Executive Council meetings and shall coordinate the activities of the chapter delegates and alternate delegates including delegate caucuses and reference committee assignments. The ~~AMA delegate co-leaders~~ AMA delegation co-chairs shall represent ~~the AMA delegates and alternate delegates~~ chapter delegates and alternate delegates to the AMA-MSS at Executive Council meetings and shall coordinate the activities of the ~~section's AMA delegates and alternate delegates~~ chapter delegates and alternate delegates including delegate caucuses ~~and reference committee assignments~~. When available, the immediate past chair shall participate in Executive Council meetings. The student serving as an alternate delegate on the Texas Delegation to the AMA and the student serving as special appointee to the TMA Board of Trustees shall represent their respective TMA components at council meetings, and shall provide the Executive Council with regular updates regarding the business thereof.

The term of office for all members of the Executive Council shall be one year~~. With the exception of the TMA delegate co-leaders, terms shall begin at the conclusion of the association's annual session and terminate at the conclusion of the following annual session. Terms for the TMA delegate co-leaders shall begin at the conclusion of the association's winter conference and~~

~~terminate at the conclusion of the following winter conference.~~ The term will begin at the conclusion of the association's annual session and terminate at the conclusion of the following annual session, with the exception of the AMA delegation co-chairs. Terms for the AMA delegation co-chairs shall begin at the conclusion of the AMA-MSS Annual Meeting and terminate at the conclusion of the following AMA-MSS Annual Meeting.

Should an outgoing AMA delegation co-chair be elected to another position on the Executive Council during an annual session, they shall hold both offices through the end of the AMA-MSS Annual Meeting but will still only have one vote for Executive Council business.

6.10 ELECTIONS.

6.11 Authority to elect. ~~Chapter representatives who are properly credentialed at section meetings as provided in Section 9.16 shall elect all members of the Executive Council.~~ Approved and active medical school chapters present at the section business meeting during which elections are held shall elect all voting members of the Executive Council, as provided in 3.10 and 4.10.

6.12 Time of elections. Elections shall be held at the section meeting in conjunction with the TMA Annual Session except as provided in 7.10.

6.13 Method of elections. Elections shall be held in the following order: chair, vice chair, reporter, TMA ~~delegate co-leaders~~ delegation co-chairs, and AMA ~~delegate co-leaders~~ delegation co-chairs. Unsuccessful candidates may run in the subsequent elections for any remaining Executive Council positions. Following the elections of chair and vice chair, the aforementioned order of positions can be adjusted at the discretion of the outgoing Executive Board.

Elections shall be by secret ballot and a simple majority of the votes cast shall be necessary to elect. Two members of the Executive Council who are not involved as candidates for any office being filled shall tally ballots. 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 a majority vote is received by one of the nominees~~ and no candidate receives a simple majority on a given ballot, the candidate receiving the fewest votes shall be eliminated and a subsequent ballot issued, until a simple majority is received by one of the candidates. When there is only one nomination, vote may be by acclamation.

No medical school shall have more than two voting members on the Executive Council.

7.10 VACANCIES. In the event of a vacancy in the position of chair, the vice chair shall serve as chair and an election shall be held to elect a new vice chair at the next meeting of the section. In the event of a vacancy in the office of vice chair or reporter, an election shall be held to fill the position at the next section meeting. In the event of a vacancy in the position of TMA ~~delegate co-leader~~ delegation co-chair or AMA ~~delegate co-leader~~ delegation co-chair, the chair shall appoint a temporary replacement until the vacant position is filled by election at the next meeting of the section.

The Executive Council shall provide adequate notice of vacancies to chapters.

8.10 REPRESENTATION AT THE AMA. The Medical Student Section shall be represented by the Texas Delegation to the AMA Medical Student Section consisting of ~~section~~ chapter delegates and alternate delegates to the AMA-MSS from each Texas chapter and led by the AMA delegation co-chairs.~~;~~ ~~section members serving in AMA and AMA-MSS offices, and on AMA councils and committees; section members running for office or presenting resolutions to the AMA-MSS; and any other section member~~

~~attending the AMA-MSS annual or interim meetings.~~ Any other section member attending the AMA-MSS annual or interim meetings are welcome to attend meetings of the delegation as non-voting participants.

Two AMA ~~delegate co-leaders~~ delegation co-chairs shall be elected as provided in Section 6.10. In the event that an AMA ~~delegate co-leader~~ delegation co-chair is unable to attend an AMA-MSS meeting, the section chair shall appoint a substitute ~~delegate co-leader~~ delegation co-chair after notifying all chapters of the vacant position.

9.10 CHAPTERS. The Medical Student Section shall be organized into chapters at each Texas medical school. ~~Each chapter shall be~~ In order to be considered an approved and active chapter, TMA-MSS staff must be able to confirm that a chapter is composed of 10 or more medical students who are currently students of that respective medical school in good standing of the section by virtue of being a member of that school's respective county medical society and TMA. Any student member in good standing of the chapter may address the chapter, participate in debate, submit resolutions for consideration by the chapter, and vote in chapter elections.

9.11 Purposes. Medical student chapters are organized to communicate information about the federation and especially that which is of specific interest to medical students; to encourage MSS leadership at the local level for better continuity of programming/service and for the development of leaders at the TMA level; to promote greater retention of members and to provide a forum for the establishment of programs; to strengthen the concept of federation membership early and the idea of working within the structure of organized medicine to achieve MSS objectives; and to increase the communication between medical students and county medical societies.

~~9.12 Names. The names of these chapters shall be Texas Medical Association Medical Student Section Chapter of Baylor College of Medicine; Texas Medical Association Medical Student Section Chapter of The Texas A&M University System Health Science Center College of Medicine; Texas Medical Association Medical Student Section Chapter of Texas Tech University Health Sciences Center School of Medicine; Texas Medical Association Medical Student Section Chapter of The University of Texas Medical Branch; Texas Medical Association Medical Student Section Chapter of The University of Texas Health Science Center at Houston Medical School; Texas Medical Association Medical Student Section Chapter of The University of Texas Medical School at San Antonio; Texas Medical Association Medical Student Section Chapter of The University of Texas Southwestern Medical School; and Texas Medical Association Medical Student Section Chapter of University of North Texas Health Science Center at Fort Worth, Texas College of Osteopathic Medicine.~~

~~9.13 Meetings. A minimum of three meetings shall be held per academic year. At least two of these meetings shall precede meetings of the section. A quorum for the conduct of business at a chapter meeting shall consist of at least 10 percent of the student members in good standing of the chapter or a majority of the chapter's governing board. Emergency meetings of the chapter may be called at the discretion of the chapter's governing board.~~

9.14 ~~Officers.~~ Chapter Officers. Each chapter shall elect, at least, the following officers: president, vice president, treasurer, TMA delegate, TMA alternate delegate, AMA-MSS delegate, and AMA-MSS alternate delegate.

9.15 ~~Elections.~~ Chapter Elections. ~~Members in good standing of the chapter shall elect all chapter officers and chapter representatives. E~~ Chapter elections shall be held at least 30 days prior to the TMA Winter Conference and ~~must~~ should be submitted to the section coordinator 21 days before the conference.

~~Officers shall be elected first, followed by election of chapter representatives and alternate representatives. Candidates must be members in good standing of the chapter. The term of office for each position shall be one year beginning and ending as determined by the chapter.~~

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

~~9.16 Chapter Representatives to the Medical Student Section. Each year, an official census of each medical school shall be taken on April 1 preceding the association's annual session to determine the number of chapter representatives to the Medical Student Section. Each chapter shall be entitled to representation according to the following formula: schools with 100 members or less are allowed 2 chapter representatives; those with 101 to 200 members are allowed 4 chapter representatives; those with 201 to 400 members are allowed 5 chapter representatives; those with 401 to 600 members are allowed 6 chapter representatives; and those with more than 600 members are allowed 7 chapter representatives.~~

~~Chapter representatives must be properly credentialed by the MSS Executive Council before each section meeting. A chapter representative shall not have more than one vote.~~

9.17 Chapter Advisors. Each chapter ~~shall request its local county medical society to select a physician member to serve as an advisor to the chapter. Advisors shall be invited to all chapter meetings, receive minutes of all meetings, and, in general, shall be made aware of all chapter activities. Chapter advisors shall serve the same one-year terms as chapter officers, but may serve additional terms at the discretion of the county medical society.~~ shall appoint a chapter advisor that is a TMA physician member in good standing and submit that advisor's information with the results of that year's chapter leadership elections.

10.10 STUDENTS ON LEAVE OF ABSENCE. A student member on "Leave of Absence" status shall continue to have full rights of TMA-MSS membership and shall be eligible to participate in leadership opportunities at the chapter, state, and national levels, provided that the student member is in good standing with the Texas Medical Association, the county medical society, and medical school, and that the student intends to finish medical school. The Executive Council shall have the authority to monitor this provision to guard against abuse.

11.10 RECALL OF SECTION OFFICERS. Any MSS Executive Council member may be recalled by a three-fourths majority vote ~~of the members present and in good standing at a section meeting.~~ as provided by Section 3.10, provided he or she is given an opportunity to address the section prior to voting, at least seven days advance notice has been given to the council member and all MSS chapters, and a quorum is reached. A special election to replace any vacancy so created may be held immediately.

12.10 RECALL OF CHAPTER RECOGNITION. Recognition of a chapter may be recalled by a majority vote of the Executive Council with concurrence of the TMA Board of Councilors and the House of Delegates. This recall may be appealed to the voting membership of the section not affected by the appeal by a two-thirds vote at a regularly scheduled section meeting.

13.10 SECTION RULES AND POLICIES. The section may ~~adopt~~ amend such rules and policies for its internal activities as the section considers necessary. All amendments shall require a two-thirds majority of votes as provided in Section 3.10. Anything not delineated in the rules and policies can be affected and

changed by a majority vote of the Executive Council. Such rules and policies shall not conflict with these operating procedures and shall not be subject to approval of the House of Delegates before implementation.

14.10 RULES OF ORDER. The Executive Council shall have the authority to establish rules of conduct, but in general and in all instances not covered by its own special rules, ~~Sturgis' *The Standard Code of Parliamentary Procedure*~~ the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* (AIP) shall govern.

15.10 AMENDMENTS. Prior to being submitted to the association's House of Delegates, these operating procedures may be amended by a two-thirds ~~vote of the members present and voting at a section meeting~~ majority of votes as provided in Section 3.10. ~~As provided in~~ In accordance with TMA Bylaws, amendments must be approved by the TMA House of Delegates to become effective.

Distributed at Meeting

REPORT OF YOUNG PHYSICIAN SECTION

YPS Report 1-A-18

Subject: Young Physician Section Operating Procedures Update

Presented by: Lindsay Botsford, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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Texas Medical Association Young Physician Section (TMA-YPS) Operating Procedures manual provides information and guidance regarding policies and protocols for the section, additional to the relevant provisions of the TMA Constitution and Bylaws. Upon review, the section identified necessary updates to clarify the election process and streamline meeting scheduling. This report details the amendments to the YPS Operating Procedures recommended by the section for approval by the House of Delegates.

Recommendation: Amendment of TMA Young Physician Section Operating Procedures, as follows:

4.10 **EXECUTIVE COUNCIL**. An executive council of the Young Physician Section shall direct the section's programs and activities.

4.11 **COMPOSITION**. The section's chair, chair-elect, and delegates and alternate delegates to TMA, and the delegates and alternate delegates to the American Medical Association shall compose the Executive Council. Should a member of the Executive Council cease to be a YPS member for any reason at any time prior to the expiration of the term for which the member was elected, the term of such member shall terminate and the position shall be declared vacant.

4.12 **ELECTION**. ~~Except as provided in 5.13, e~~Elections shall be held at the section's annual meeting unless otherwise specified. Ballots may be sent to section members electronically and utilized for voting. Any YPS member shall be eligible for election to the Executive Council. Approval by a simple majority of the votes cast, via ballot in person or via email, shall be required to elect members of the Executive Council. Vacancies shall be handled by the procedure set forth in 5.13.

4.13 **ASSUMPTION OF OFFICE**. All members of the Executive Council shall assume office at the conclusion of the section's annual meeting.

4.14 **MEETINGS**. The Executive Council should meet at least once annually, and then as needed between meetings to direct section business.

4.15~~43~~ **ATTENDANCE**. If any member fails to attend two consecutive Executive Council meetings, the office will be declared vacant and will be filled by appointment of the chair until the next regularly scheduled section meeting, at which time an election for the vacancy will occur.

5.10 **CHAIR, CHAIR-ELECT, IMMEDIATE PAST CHAIR**.

5.11 **DUTIES**. The chair shall preside at all section and Executive Council meetings. The chair-elect shall assist the chair and preside at meetings in the absence of the chair

or at the chair's request. The immediate past chair shall participate in section Executive Council meetings and advise the chair.

5.12 **TERM**. Term of office shall be one year. The chair-elect shall be elevated to the office of chair, and the chair shall serve as immediate past chair.

5.13 **VACANCY**. In the event of a vacancy in the office of chair, the chair-elect shall assume the office of chair. In the event the offices of chair and chair-elect become vacant, both offices shall be filled by election at the next meeting of the section, the office of chair being filled first. Their terms shall fulfill the unexpired terms of the officers replaced.

6.10 **DELEGATES AND ALTERNATE DELEGATES TO TMA HOUSE OF DELEGATES**.

6.11 **DUTIES**. The delegates and alternate delegates shall represent the section in the TMA House of Delegates.

6.12 **TERM**. The term of delegates and alternate delegates shall be two years. Tenure shall not exceed two terms, except that election to or assumption of an unexpired term shall not be regarded as tenure in office. Delegates and alternate delegates shall be elected in opposite years.

6.13 **QUALIFICATION**. Any YPS member in good standing may be elected to serve as a delegate or alternate delegate from the section.

7.10 **DELEGATE(S) AND ALTERNATE DELEGATE(S) TO AMA YOUNG PHYSICIANS SECTION.**

7.11 **DUTIES**. The delegate(s) and alternate delegate(s) to the AMA-YPS shall represent the section at the AMA Young Physicians Section.

7.12 **COMPOSITION**. The number of d~~D~~elegates and alternate delegates elected shall be ~~elected~~ in accordance with the Bylaws of that organization. In the event that the number of seats for delegates allotted to the section decreases, the corresponding number of delegates with the shortest tenure shall become alternate delegates.

If, after such reapportionment, there are more alternate delegates than seats for delegates, the appropriate number of alternate delegates with the shortest tenure shall be dropped.

7.13 **TERM**. Delegates and alternate delegates shall be elected annually and shall assume office at the conclusion of the AMA annual meeting that immediately follows the section's annual meeting.

7.14 **ELECTION.** Elections shall be held at the section's winter meeting. Any YPS member that is also a member of the AMA shall be eligible for election to the Executive Council.

8.10 **MEETINGS**.

The section shall meet upon call of its chair, at least once a year.

A section member vote on any matter may be conducted by mail, by facsimile transmission, by electronic message, or by a combination of those methods. Action may be taken without a meeting if a signed written consent stating the action to be taken is received from a majority of voting members.

~~An annual meeting shall be held in conjunction with TMA's annual session, TexMed. The section also shall meeting in conjunction with the association's fall and winter meetings. The purposes of meetings are to: (1) consider and adopt resolutions section members submit; (2) hear appropriate reports; (3) consider and vote upon any issues of concern to young physicians; and (4) ratify policy made by the Executive Council and between meetings. Elections shall be held at the annual meeting as provided in 1.132 or at other section meetings to fill vacancies as provided in 1.133.~~

9.10 **VOTING AND VOICE**. Any section member may attend, introduce resolutions or reports, debate issues, and vote ~~at section meetings~~ in elections. At the discretion of the chair, other TMA members may be permitted voice at section meetings. County medical societies are encouraged to send representatives to each meeting.

10.10 **QUORUM**. At least six ~~seven~~ Executive Council members must be present for the ~~YPS or the~~ Executive Council to transact business. At least ten young physician members must be present for the YPS to conduct business.

11.10 **RULES OF ORDER**. The deliberations of the section shall be governed by the TMA House of Delegates rules of order.

12.10 **NOTICE OF MEETINGS**. Notice of the meetings shall be provided to section members at least ~~45~~ 30 days prior to the meetings. Any business, reports, or resolutions the section is to consider must be submitted in writing to the Executive Council at least 14 ~~30~~ days prior to the meeting. Late reports and resolutions must be submitted to the Executive Council ~~at its meeting immediately preceding the section meeting at which consideration is desired~~ for consideration. All such reports and resolutions so presented shall require a two-thirds affirmative vote to be accepted as business to be acted upon by the section.

13.10 **AMENDMENTS**. Prior to being submitted to the TMA House of Delegates, these operating procedures may be amended by a two-thirds vote of the members present and voting at a section meeting. As provided in TMA Bylaws, amendments must be approved by the TMA House of Delegates to become effective.

Updated April 27, 2018 ~~May 4, 2006~~

REPORT OF COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-A-18

Subject: Amendments to the TMA Constitution

Presented by: Mark A. Casanova, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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At the 2013 Annual Session, the House of Delegates approved a constitutional amendment to Article VI of the TMA Constitution, as well as bylaws amendments, recognizing the election of a young physician member to the Board of Trustees (CCB Rep. 9-A-13). The Council on Constitution and Bylaws recommends final action on the constitutional amendment and insertion into the TMA Constitution.

In addition to establishing this position, voting rights in the House of Delegates for the young physician board member must be formally recognized in the TMA Constitution as they are in the bylaws. The council recommends a constitutional amendment to Article V, House of Delegates. Upon passage on first reading, the amendment must rest for second passage with final action due at the annual session in 2019.

Recommendation 1: Amend Constitution Article VI, BOARD OF TRUSTEES, as follows:

ARTICLE VI. BOARD OF TRUSTEES.

The Board of Trustees shall be composed of at-large members elected as provided in the bylaws and, ex officio, with vote, the president, president-elect, immediate past president, secretary/treasurer and speaker and vice speaker of the House of Delegates; one young physician who shall be elected as provided in the bylaws, and one resident and one student member, who shall be appointed annually. This board shall establish interim policy of the association. All policies established by the Board of Trustees shall be subject to ratification by the House of Delegates. The Board of Trustees shall perform other duties as defined in the Bylaws and as may be established by the House of Delegates. The board shall meet at intervals between meetings of the House of Delegates.

The Board of Trustees shall manage the business and financial affairs of the association. All association funds shall be subject to the exclusive control of the Board of Trustees except as otherwise provided in the Bylaws. The Board of Trustees shall serve in general as a board of directors within the meaning of the corporate laws of the State of Texas.

Recommendation 2: Amend Constitution Article V, HOUSE OF DELEGATES, as follows:

ARTICLE V. HOUSE OF DELEGATES.

Sec. 1. The legislative and policy-making body of the association shall be the House of Delegates. The House of Delegates shall transact all business of the association not otherwise specifically provided in this Constitution and Bylaws, shall elect the officers except as otherwise provided in the Bylaws, and shall meet as provided in the Bylaws.

Sec. 2. House of Delegates membership shall consist of:

(1) Delegates representing county medical societies, elected in accordance with this Constitution and Bylaws; and

(2) Ex officio members, including
(a) The president, president-elect, immediate past president, secretary/treasurer, and speaker and vice speaker of the House of Delegates;
(b) Councilors;
(c) Nine members elected at large to the Board of Trustees plus the young physician, resident, and student members of the board.
(d) Texas delegates and alternate delegates to the American Medical Association;
(e) Chairs of standing councils and members of the Council on Legislation;
(f) Delegates from the International Medical Graduate Section, Resident and Fellow Section and Young Physician Section;
(g) Delegates representing the Medical Student Section from each approved and active Medical Student Section Chapter;
(h) Delegates of medical specialty societies selected in accordance with this Constitution and Bylaws;
(i) Past presidents of the association who are active or emeritus members; and
(j) As nonvoting members, the chair of TEXPAC and delegates emeritus of the AMA delegation.

REPORT OF COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-A-18

Subject: Election of TMA Board of Trustees Members, Filling Vacancies by Special Election (Resolution 101-A-17)

Presented by: Mark A. Casanova, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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Background

The House of Delegates at A-17 referred to the Council on Constitution and Bylaws and the TMA speakers of the house Resolution 101, Election of TMA Board of Trustees Members, Filling Vacancies by Special Election (Lone Star Caucus). The resolution asks that: (1) 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; (2) TMA Bylaws, Chapter 4, Board of Trustees, Section 4.40, Term, tenure, and vacancies of at-large members, be amended; and (3) TMA Bylaws, Chapter 7, Elections, Section 7.42, Balloting, Subsections 7.421, First ballot, and 7.422, Run-off ballot, be amended.

Discussion

The Council on Constitution and Bylaws undertook a thorough examination of the issues outlined in the resolution. This included a review of the Board of Trustees election process, balloting measures, term length, and total lifetime of service. Using their findings, the council collaborated with the Speakers' Advisory Committee at the 2017 fall conference and 2018 winter conference to achieve consensus on recommendations to address the resolution's intent.

First, elimination of unexpired terms would allow candidates elected or appointed as at-large members of the Board of Trustees to receive three-year terms whether the vacancy was scheduled or unscheduled. Candidates would know the term length in advance of the campaign and election.

In addition, the speakers and the council recommend reducing the total lifetime of service on the Board of Trustees from 10 years to nine to continue to ensure a dynamic election process. This reduction in total lifetime service on the board will provide regular turnover and even greater opportunities for physician members to elevate within TMA leadership.

This proposal is intended for implementation beginning with the 2018 elections, ensuring that current at-large and ex-officio board members elected prior to 2018 do not experience a change in the term and tenure provisions in place at the time of their initial election to the board.

Therefore, in lieu of Resolution 101-A-17, and in support of SPKR Report 2-A-18, the council recommends the following amendments to TMA Bylaws.

Recommendation 1: Amend Bylaws Chapter 4, Board of Trustees, Section 4.40, as follows:

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 reelection. The two-year young physician term shall not count toward the lifetime service limit of ~~10~~ nine 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~~ nine 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~~ vacancies to be filled 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 house election.

Recommendation 2: Amend Bylaws Chapter 7, Elections, Section 7.42, Balloting, Subsection 7.421, First ballot, and Subsection 7.422, Run-off ballot, as follows:

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 the 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 on 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 term lengths of positions to be filled, those receiving the highest majorities shall be elected to the longer terms.~~

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~~.

REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSPH Report 1-A-18

Subject: Rejection of Discrimination (Resolution 304-A-17)

Presented by: David Lakey, MD, Chair, Council on Science and Public Health
G. Sealy Massingill, MD, Chair, LGBT Workgroup

Referred to: Reference Committee on Financial and Organizational Affairs

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The 2017 House of Delegates considered one report and several resolutions related to sexual orientation, gender identity, and health care. This included Resolution 304 by the Resident and Fellow Section and the Medical Student Section calling for TMA's rejection of discrimination and requiring TMA to adopt policy opposing any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin, or age. The second resolve called for TMA to work with other organizations, public and private, to identify and make resources available to assist physicians regarding care for the lesbian, gay, bisexual, transgender, and questioning (LGBTQ) population.

Upon adoption, Resolution 304-A-17 was referred to the Council on Science and Public Health for action. The council appointed a workgroup on LGBT, chaired by G. Sealy Massingill, MD, to address several activities called for in the resolution. This report addresses the first resolve on nondiscrimination policy.

LGBT Health and Discrimination

Resolution 304 reported that LGBTQ individuals were at increased risk of disease including psychiatric disorders, substance abuse, and suicide, and that transgender individuals, in particular, have higher rates of sexually transmitted infections and victimization, mental health diagnoses, and suicide. Further, LGBTQ youth are at particular risk of adverse health outcomes, including suicide attempts.

With a lack of understanding of the health of certain U.S. populations, in 2011 the U.S. Department of Health and Human Services (HHS) expanded its research and related activities to include an assessment of the health status of sexual and gender minorities. The 2013 and 2016 National Health Interview Surveys (NHISs) of the Centers for Disease Control and Prevention (CDC) are the first nationally representative surveys with questions on sexual orientation. From NHIS, CDC estimates that about 1.6 percent of adults in the United States identify as gay or lesbian, and 0.7 percent identify as bisexual (a small proportion of responders [1.1 percent] identified as "something else" or "don't know," or did not answer). CDC also has estimated that more than 1 million adults in the United States identify as transgender, with 85 percent of these as transgender women. These recent surveys also have supported the development of health goals related to LGBT health in Healthy People 2020.

The 2014 NHIS overview on the health-related behaviors of people who identify as gay, lesbian, or bisexual reported both higher current cigarette use and higher alcohol consumption compared with the straight population surveyed, although physical activity levels were comparable with the straight adult population. While there were no significant differences among gay males and the general population who identified as "in excellent" or in "very good health," women who identified as gay or lesbian were less likely to report excellent or very good health. Health care access was found to vary depending on age group. Compared with those who identified as straight, women aged 18-64 who identified as gay, lesbian, or bisexual were less likely to have a regular source of medical care, while adults aged 18-64 who identified as straight were less likely to get the medical care they needed because of cost, compared with those who identified as bisexual.

Discrimination related to health access has long been a major area of study, but research on discrimination based on LGBT status has been limited. A meta-analytic review of studies on perceived discrimination concluded that discrimination can contribute to both physical and mental health outcomes, from a range of mental health symptoms and poor mental health status to increasing risk factors for disease. A 2010 study that surveyed black, Hispanic, and LGB people reported an association between the perception of discrimination and health. Those who reported recent discrimination (e.g., at work, in restaurants, or in stores) were much more likely to report a mental health disorder. For some, over time, discrimination or perceived discrimination can become a stressor and may have an effect on behavior and health. A 2016 study of the NHIS 2013 and 2014 responses on LGB health showed higher levels of moderate or severe psychological stress as well as higher alcohol and tobacco use (both moderate and heavy) among LGB males and females than among heterosexuals. The authors attribute these disparities in health to the "minority stress" experienced by LGB adults facing discrimination.

Nondiscrimination Laws and Policy

Federal laws and federal court decisions establish a framework that addresses discrimination in all sectors of American life, from the workplace, to where one can live or go to school, to voter eligibility. The Civil Rights Act of the 1960s is identified as legislation on the right to vote and employment, but it also addresses many other areas of the law. The principles of equal protection and access in the Civil Rights Act and other federal legislation continue to be studied and litigated throughout the country, and increasingly this includes the application of nondiscrimination laws to LGBTQ individuals.

More recently, health care has become a central focus in addressing nondiscrimination because of the federal interest in clarifying access to the benefits provided under the 2010 Affordable Care Act (ACA). Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. The programs in Section 1557 include any health program or activity regulated or funded by HHS. This extends to the activities and plans managed by health insurers participating in the health insurance marketplace.

While defining sex discrimination, the final rule of the HHS Office of Civil Rights published in May 2016 outlines that sex discrimination also includes gender identity. Some of the key components related to gender identity in these federal rules are as follows:

- The definition of "on the basis of sex" in §92.4 means (but is not limited to) discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity.
- The definition of gender identity includes male, female, neither, or a combination of male and female including people with nonbinary gender identities.
- Gender identity means an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth. The way an individual expresses gender identity or "gender expression" may or may not conform to social stereotypes associated with a particular gender. A transgender individual is an individual whose gender identity is different from the sex assigned to that person at birth.
- §92.206 requires a covered entity to provide equal access to its health programs without discrimination on the basis of sex and treat individuals consistent with their gender identity.
- §92.207 requires nondiscrimination in health-related insurance and other health-related coverage. An entity may not deny or limit coverage, deny a claim, or impose additional cost sharing or other limitations for health services related to gender transition.

The U.S. District Court for the North District of Texas issued an opinion at the end of 2016 that enjoined HHS from implementing the guidance on prohibiting discrimination on the basis of sexual identity, and

this remains. While HHS is not enforcing the regulations prohibiting sex discrimination including gender identity in the programs in Section 1557 of the ACA, the rules provide clear language on components of sex discrimination in the context of health care.

Texas Nondiscrimination Laws

Texas laws provide equal protection and application to various components of state government and statutes but are most notably related to employment, housing, the judicial system, and education. Generally, Texas statutes recognize a person's race, color, religion, sex, marital status, or national place of origin as characteristics that place a person in a protected class and prohibit discrimination. State statute does not specifically address LGBT orientation, gender identity, or gender expression.

While legislation on LGBT equality, and transgender equality in particular, has been considered by the Texas Legislature in various areas (adoption, birth certificates, same-sex marriage, public facility use), these efforts have not been considered as supportive or inclusive of LGBT individuals. There are no provisions in state statute that specify the same protections for LGBT individuals as provided other Texans. However, several urban Texas cities (Austin, Dallas, Fort Worth, and Plano) have established local ordinances that prohibit discrimination against LGBT individuals in different areas (housing, public facilities, employment). A number of school districts and some college campuses also have adopted nondiscrimination policies.

Discussion

An Institute of Medicine 2011 report noted that increasing our understanding of the health of sexual minorities should take into consideration historical and cultural contexts. A cultural context is where sexual orientation and expression in an environment may involve bullying, abuse, family disorder, risk taking, and poor access to health care, which may last throughout the lifespan. The historical context relates to discrimination, and most recently, the stigma of HIV/AIDS, and also direct legal barriers that long have been associated with people who do not identify as heterosexual.

The goal of nondiscrimination laws and policies is to provide each individual equal protection under the law so that each has opportunities to pursue an independent life as established in the U.S. Constitution. Many reports show that a large proportion of LGBT individuals do not have equal access to health care, and many report discrimination in particular. These appear to be factors in poor health outcomes in LGBT individuals.

While physicians recognize that improved awareness of the health care needs of LGBT individuals is critical, the council also understands the urgent and significant health risks and concerns of LGBT individuals and the potential impact of a clear statement acknowledging that all are entitled to the same protections provided to other Texas residents. In the absence of clear state nondiscrimination policy for all and as directed by the 2017 House of Delegates, the council recommends the following additions to the TMA Policy Compendium:

Recommendation 1: That the Texas Medical Association does not discriminate based on race, religion, disability, ethnic origin, national origin, age, sexual orientation, sex, or gender identity; and

Recommendation 2: That TMA supports physician efforts to encourage that the nondiscrimination policies in their practices, medical schools, hospitals, and clinics be broadened to include "race, religion, disability, ethnic origin, national origin, age, sexual orientation, sex, or gender identity" in relation to patients, health care workers, and employees.

Related TMA Policy:

245.005 Age Discrimination: The Texas Medical Association believes the same standard of proof of mental and physical competence to practice medicine and obtain professional liability insurance should be uniform for all physicians without discrimination as to age (Res. 28H, p 185, I-93; reaffirmed BOC Rep. 3-A-03; reaffirmed BOC Rep. 6-A-13).

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 origin or geographic location of medical school (Amended Res. 301-I-99; amended BOC Rep. 6-A-09).

60.005 Equal Rights: All individuals should have access to equal social, economic, and professional opportunities (Medical Student Section, p 123, A-95; reaffirmed BOC Rep. 3-A-05; reaffirmed BOC Rep. 4-A-15).

Related AMA Policy:

Nondiscriminatory Policy for the Health Care Needs of LGBT Populations H65.976 That the American Medical Association encourage 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.

Nondiscriminatory Policy for the Health Care Needs of LGBT Populations D-65.996. 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."

Sources:

1. Centers for Disease Control and Prevention, Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013; Sexual Orientation among U.S. adults age 18 and over, 2014.
2. Centers for Disease Control and Prevention, HIV Among Transgender People, www.cdc.gov/hiv/group/gender/transgender/index.html, accessed Nov. 6, 2017.
3. Transgender Population Size in the United States: A Meta-Regression of Population-Based Probability Samples, *American Journal of Public Health*, February 2017.
4. Pascoe EA, Richman LS, Perceived Discrimination and health: A Meta-Analytic Review, *American Psychological Association*, 2009 July 135(4).
5. McLaughlin KA, Hatzenbuehler M, et al., Responses to discrimination and psychiatric disorders among black, Hispanic, female, and lesbian, gay, and bisexual individual, *American Journal of Public Health*, 2010, 100(8).
6. Gonzalez G, Przedworski J, et al., Comparison of Health and Health Risk Factors Between Lesbian, Gay, and Bisexual Adults and Heterosexual Adults in the United States, Results from the National Health Interview Survey, *JAMA Intern Med*, 2016; 176(9), June 26, 2016.
7. Human Rights Campaign, Cities and Counties with non-discrimination ordinances that include gender, www.hrc.org/resources/cities-and-counties-with-non-discrimination-ordinances-that-include-gender, accessed Nov. 6, 2017.
8. Institute of Medicine Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. Washington (DC): National Academies Press (US); 2011.

REPORT OF PATIENT-PHYSICIAN ADVOCACY COMMITTEE

CM-PPA Report 2-A-18

Subject: Review of Policy 265.019 Disruptive Behavior Standard

Presented by: R. Larry Marshall, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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The Patient-Physician Advocacy Committee (PPAC) recently reviewed a physician's legal case relating to behavioral standards and the cultures of safety that should exist at facilities. The committee committed to educate Texas Medical Association members about the latest developments relating to physician behavioral standards. Accordingly, PPAC reviewed the evolution of the "disruptive behavior" standard The Joint Commission (TJC) promoted at one time.

In 2008, TJC published a new leadership standard that required accredited health care organizations to create a code of conduct defining acceptable, disruptive, and inappropriate behaviors and to establish formal processes for managing unacceptable behavior.

In response to the 2008 TJC standard, the American Medical Association adopted Resolution 1 (I-08), which reflected a concern that hospitals could misuse the term "disruptive physician" if there was no clear definition of what acts by a physician rise to the level of truly disruptive behavior. In response, the AMA Council on Ethical and Judicial Affairs reviewed its Opinion E-9.045; AMA's Organized Medical Staff Section adopted model medical staff codes of conduct that followed TJC's standards; and AMA adopted Policy H 225.956, Behaviors that Undermine Safety, which encouraged TJC to stay implementation of its new leadership standard for a year to allow adequate time for medical staffs to bring bylaws into compliance. Despite AMA's opposition, TJC implemented its new leadership standard in 2009.

TMA expressed support for AMA's actions by adopting policy 265.019, which committed TMA to disseminating information on the disruptive physician standard and to helping AMA seek amendments to the standard.

Because of continued opposition by groups including AMA and TMA, TJC eventually amended the "disruptive behavior" standard in 2012. The standard removed references to "disruptive behavior" and instead used "behaviors that undermine a culture of safety."

In making the change, TJC stated that it had used the term "disruptive behavior" because it was commonly used in the literature and recognized by most individuals in the workplace. TJC further stated that it had since learned the term "is not viewed favorably by some health care practitioners and is even considered ambiguous for some audiences." TJC acknowledged that ambiguity by citing an example in which "strong advocacy for improvements in patient care can be characterized as disruptive behavior."

Although TJC continues to discourage the use of "disruptive behavior" in behavioral standards, TMA's policy does not reflect this. As a result, PPAC recommends amending TMA policy to reflect recent changes to behavioral standards and to discourage the use of "disruptive behavior" or "disruptive physician" to avoid the improper label of proper advocacy for patient care as being "disruptive."

Recommendation: Amend TMA Policy 265.019 to read as follows:

265.019 **Physician ~~Disruptive~~ Behavior Standards:** The Texas Medical Association encourages bylaws and policies that promote a safety culture and asserts that standards for physician behavior should not use ambiguous terms that can be used against physicians for retaliation or for economic gain. TMA will encourage hospital medical staffs, the American Medical Association, and other appropriate entities to amend applicable resources and policies to replace the terms "disruptive behavior" and "disruptive physician" with references to "unprofessional behavior" or "behavior that undermines a culture of safety" to reflect amendments The Joint Commission has made to its leadership standards ~~will aid and assist the AMA in distributing to Texas physicians the resource materials developed on the "disruptive physician," compiling the experiences of hospital medical staffs and physicians in satisfying the new Joint Commission leadership standard on "disruptive physicians," and seeking amendments to this standard as indicated~~ (Amended CM-PHR Rep. 5-A-09).

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 101
A-18

Subject: Patient-Centered Medical Record Responsibilities

Introduced by: Webb-Zapata-Jim Hogg County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

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Whereas, Today, Texans are increasingly living in a mobile society and get health care from more than one physician or health care provider, and from multiple facilities; and

Whereas, A patient may voluntarily seek to change physicians or health care providers, be forced to change because of third-party payers, need to change when reaching adulthood, or be displaced because of a natural disaster, all of which may create information gaps in the patient's medical record; and

Whereas, The Texas Medical Association promotes a patient-centered medical home but this may not totally resolve the issue of the silo effect of the patient's medical information as the patient may migrate from one home to another; and

Whereas, Many Texans already have their health information available in electronic format that can be downloaded; and

Whereas, In order to promote patient engagement in health and medical decisions, patients will need easy access and knowledge of their health data and the ability to share the data with their physicians and others to improve health care outcomes; therefore be it

RESOLVED, That the Texas Medical Association encourage appropriate organizations, e.g., disaster preparedness agencies, utility companies, and county health departments, to educate Texans on the importance of having access to or possession of an accurate summary of their medical record whenever and wherever it is needed; and be it further

RESOLVED, That the Texas Medical Association support a legislative proclamation that designates a Texans Medical Record Checkup Day at the beginning of hurricane and tornado season to encourage Texans to have access to or possession of an accurate summary of their medical record should it be needed.

Related TMA Policy:
255.004 Patient-Centered Medical Home: A patient centered medical home (PCMH) is a primary care physician or team who ensures that patient care is accessible, coordinated, comprehensive, patient-centered, and culturally relevant through the direct provision, coordination, or arrangement of health care or social support services as indicated by the patient's individual medical needs and the best-available medical evidence.

Principles of a patient centered medical home (as articulated by AAFP, the American College of Physicians, Association of American Physicians, and American Osteopathic Association) are as follows.

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact and continuous and comprehensive care;

Physician-directed medical practice - the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation - the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, and end-of-life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home, meaning (1) practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership among physicians, patients, and the patients' families; (2) evidence-based medicine and clinical decision-support tools guide decision making; (3) physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement; (4) patients actively participate in decision-making, and feedback is sought to ensure patients' expectations are being met; (5) information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication; (6) practices go through a voluntary recognition process by an appropriate nongovernmental entity to demonstrate they have the capabilities to provide patient-centered services consistent with the medical home model; and (7) patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication among patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. It should (1) reflect the value of patient-centered care management work by physicians and nonphysician staff that falls outside of the face-to-face visit; (2) pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources; (3) support adoption and use of health information technology for quality improvement; (4) support provision of enhanced communication access such as secure e-mail and telephone consultation; (5) recognize the value of physician work associated with remote monitoring of clinical data using technology; (6) allow for separate fee-for-service payments for face-to-face visits (payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits); and (7) recognize case mix differences in the patient population being treated within the practice (SC-MCU Rep. 1-A-08).

265.012 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 4 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.

5. TMA supports the study and evaluation of the potential impact that physician efforts directed towards compliance with unduly burdensome state and federal regulation may have on patient care. These new compliance burdens compete for the physician's attended and limited resources and may distract the physician from patient care (Amended Res. 402-A-05; amended CPMS Rep. 3-A-07; substituted CPMS Rep. 2-A-10; amended CPMS Rep. 2-A-13; amended CPMS Rep. 1-A-14).

Related AMA Policy:

Data Ownership and Access to Clinical Data in Health Information Exchanges H-478.988

1. Our AMA: (A) will continue its efforts to educate physicians on health information exchange (HIE) issues, with particular emphasis placed on alerting physicians to the importance of thoroughly reviewing HIE business associate contracts and clarifying any and all secondary uses of HIE data prior to agreeing to participate in a particular HIE; (B) will advocate for HIEs to provide an overview of their business models and offered services to physicians who are considering joining the organization; (C) will advocate for HIE contracts to clearly identify details of participation, including transparency regarding any secondary uses of patient data; (D) will advocate that HIEs comply with all provisions of HIPAA in handling clinical data; and (E) encourages physicians who experience problems accessing and using HIE data to inform the AMA about these issues. 2. Our AMA supports the inclusion of actively practicing physicians and patients in health information exchange governing structures. 3. Our AMA will advocate that physician participation in health information exchanges should be voluntary, to support and protect physician freedom of practice. 4. Our AMA will advocate that the direct and indirect costs of participating in health information exchanges should not discourage physician participation or undermine the economic viability of physician practices. (BOT Rep. 17, A-13; CMS Rep. 6, A-13; Reaffirmed: CMS Rep. 4, I-13)

Principles of the Patient-Centered Medical Home H-160.919

1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows:

Principles

Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole Person Orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

Evidence-based medicine and clinical decision-support tools guide decision making.

Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

It should recognize case mix differences in the patient population being treated within the practice.

It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements.

2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care.

3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.

4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.

5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home. (Res. 804, I-08; CMS Rep. 8, A-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmed: Res. 723, A-11; Appended: Res. 723, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed in lieu of Res. 706, A-12)

Sources:

Clinical Gastroenterology and Hepatology 2017; 15: xix-xx

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 103
A-18

Subject: Internet-Based Notification of Patients When a Physician Is Closing or Leaving a Practice

Introduced by: Travis County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

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Whereas, When a physician retires, terminates employment, or otherwise leaves a medical practice, the physician must ensure that patients receive reasonable notification; and

Whereas, According to the Texas Administrative Code, Title 22, §165.5(b)(2): "Notification shall be accomplished by: (A) publishing notice in the newspaper of greatest general circulation in each county in which the physician practices or practiced and in a local newspaper that serves the immediate practice area; (B) placing written notice in the physician's office; and (C) sending letters to patients seen in the last two years notifying them of discontinuance of practice"; and

Whereas, The role of printed media is shrinking, and printed mail is being replaced by electronic communications; and

Whereas, More and more patients access the information of medical practices on the internet, and insurers are promulgating the internet-based approach as well; therefore be it

RESOLVED, That the Texas Medical Association work with the Texas Medical Board and the Texas Legislature to change §165.5(b)(2) of the Texas Administrative Code to allow the notification of patients to be accomplished by posting a notice the physician's website as a stand-alone method in addition to placing a notification in the physician's office; and be it further

RESOLVED, That the Texas Medical Association formally recommend to the Texas Medical Board amendment of the current provisions of Texas Administrative Code §165.5(b)(2) as follows: "Notification shall be accomplished by: (A) <u>posting a notice on the website of the physician, to be kept available for two years, or</u> publishing notice in the newspaper of greatest general circulation in each county in which the physician practices or practiced ~~and in a local newspaper that serves the immediate practice area~~; (B) placing a written notice in the physician's office; and (C) sending <u>an email notice or postal</u> letter~~s~~ to patients seen in the last two years notifying them of discontinuance of practice."

Related TMA Policy: None found.

Related AMA Policy: None found.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 104
A-18

Subject: Clarification of Guidelines for Online Prescribers in Texas

Introduced by: Travis County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

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Whereas, Telemedicine is a means of providing a medical service, consistent with accepted standards of care and the establishment of a valid patient-physician relationship; and

Whereas, When telemedicine is medically necessary, there should be no state or federal prohibition against physicians with a valid patient-physician relationship diagnosing patients with mental and behavioral health disorders, consistent with accepted standards of care, and prescribing appropriate medications, including controlled substances, for these patients; and

Whereas, There is no state or federal prohibition against physicians with a valid patient-physician relationship prescribing medications of controlled or uncontrolled classes via telehealth or online; therefore be it

RESOLVED, That the Texas Medical Association support national efforts to amend federal law and federal Drug Enforcement Administration regulations to allow for the e-prescribing of a medication, including a controlled substance, needed by a patient with a mental health or behavioral health diagnosis when an appropriate patient-physician relationship has been established through telemedicine and in accordance with state law and accepted standards of care; and be it further

RESOLVED, That our Texas Delegation to the American Medical Association take this, or a similar, resolution to the AMA House of Delegates for consideration.

Related TMA Policy:

105.002 Patient and Physician Relationship: If a physician does not have the training or expertise to treat the patient's health concerns, the physician should refer the patient to a physician or other health care professional with the appropriate training and experience (Council on Communication, p 73, I-92; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

290.003 Telemedicine Use As a Supportive Mechanism: The Texas Medical Association supports (1) development of guidelines and safeguards for the use of technology as a supportive mechanism in the delivery of health care; (2) adequate training and credentialing of health care personnel utilizing telecommunications as a mechanism to support the delivery of health care; and (3) quality assurance and peer review requirements for the utilization of telecommunications as a mechanism to support health care delivery (Council on Medical Education, pp 88-89, I-92; reaffirmed CME Rep. 7-A-03; reaffirmed CMS Rep. 1-A-13).

290.002 Telemedicine Use to Improve Health Care: The Texas Medical Association believes that its goal of improving the health of all Texans is supported by telecommunications systems that will provide physicians with continuing medical education resources as well as services that enhance health care

delivery (Committee on Access to Health Care, pp 92-93, A-92; reaffirmed CME Rep. 7-A-03; amended CME Rep. 1-A-13).

Related AMA Policy:
Coverage of and Payment for Telemedicine H-480.946
1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:

a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:

- A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or

- A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or

- Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.

c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.

d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.

e) The delivery of telemedicine services must be consistent with state scope of practice laws.

f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.

g) The standards and scope of telemedicine services should be consistent with related in-person services.

h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.

i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.

j) The patient's medical history must be collected as part of the provision of any telemedicine service.

k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.

l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.

m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.

4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.

5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.

6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

The Promotion of Quality Telemedicine H-480.969

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

(a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state;

(b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation;

(c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and

(d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize

principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions.

(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties).

Revised for Supplement
Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 105
A-18

Subject: Revision of Section 165.155 (a) of the Texas Occupations Code, Solicitation of Patients

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

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Whereas, Section 165.155 (a) of the Texas Occupations Code makes it a Class A misdemeanor if any physician employs or agrees to employ, pays or promises to pay, or rewards or promises to reward any person, firm, association, partnership, or corporation for securing or soliciting a patient or patronage; and

Whereas, It can be construed that when any physician advertises or gives group discounts; solicits and pays an individual to become a patient for research; or sends any type of favor or gift, offers a discount, or sends gift certificates for treatments to friends, past patients, or colleagues that have referred patients, that physician is committing a Class A misdemeanor; therefore be it

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

Related TMA Policy: None found.

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

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

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

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

Furthermore, any remuneration or return on investment should be based on the physician's percentage of capital investment and not on utilization, or the volume or value of referrals of patients to a particular facility. It is not unethical for a physician to recover his or her investment in such a facility and earn a reasonable rate of return.

Do not engage in fee splitting. Payment by one physician to another solely for the referral of a patient is fee splitting and is improper both for the physician making the payment and the physician receiving the payment.

Fee splitting violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral.

All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed.

The Board of Councilors reminds physicians that fee splitting is a violation of TMA Bylaws and may subject a member to disciplinary action.

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

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

Comply with applicable law. Federal and state law prohibits incentive payments designed to induce physicians to admit patients to a hospital or other health care facility. Physicians may not lawfully or ethically accept such payments. Physicians may not ethically accept any payment, directly or indirectly, overtly or covertly, in cash or in kind, from a health care facility for services delivered by the facility.

Further, the Medical Practice Act, as interpreted by the Office of the Attorney General of Texas, may prohibit the direct division on a percentage basis of a physician's professional income with lay persons or to lay shareholders in a corporation or other business enterprise.

Duty to seek responsible change. Physicians recognize an ethical responsibility to seek changes in those requirements which are contrary to the best interests of the patient. The Board of Councilors believes that

physicians have a right to seek changes in those laws which unduly restrict physician participation in health care facilities which primarily exist to serve the interest of the patient, do not result in exploitation of patients, do not involve fee splitting or other improper incentive payments, and do not present unresolvable conflicts of interest. It is in the best interest of the patient and community, not the physician, that such arrangements be allowed to continue.

Related AMA Policy:
Physicians' Self-Referral H-140.861
Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships--including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices--are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:

(1) Ensure that referrals are based on objective, medically relevant criteria.

(2) Ensure that the arrangement:

(a) is structured to enhance access to appropriate, high quality health care services or products;

(b) within the constraints of applicable law:

(i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;

(ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and

(iii) adheres to fair business practices vis-a-vis the medical professional community--for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.

(3) Take steps to mitigate conflicts of interest, including:

(a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;

(b) establishing mechanisms for utilization review to monitor referral practices; and

(c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.

(4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.

11.3.4 Fee Splitting

Patients must be able to trust that their physicians will be honest with them and will make treatment recommendations, including referrals, based on medical need, the skill of other health care professionals or facilities to whom the patient is referred, and the quality of products or services provided.

Payment by or to a physician or health care institution solely for referral of a patient is fee splitting and is unethical.

Physicians may not accept:

(a) Any payment of any kind, from any source for referring a patient other than distributions of a health care organization's revenues as permitted by law.

(b) Any payment of any kind, from any source for prescribing a specific drug, product, or service.

(c) Payment for services relating to the care of a patient from any health care facility/organization to which the physician has referred the patient.

(d) Payment referring a patient to a research study.

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

AMA Principles of Medical Ethics: II

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

9.6.3 Incentives to Patients for Referrals

Endorsement by current patients can be a strong incentive to direct new patients to a medical practice and physicians often rely on word of mouth as a source of referrals. However, to be ethically appropriate, word-of-mouth referrals must be voluntary on the part of current patients and should reflect honestly on the practice.

Physicians must not offer financial incentives or other valuable incentives to current patients in exchange for recruitment of other patients. Such incentives can distort the information patients provide and skew the expectations of prospective patients, thus compromising the trust that is the foundation of patient-physician relationships.

AMA Principles of Medical Ethics: I,II,VIII

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

Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 106
A-18

Subject: Creation of a TMA Ad Hoc Committee on the Power and Influence of the Texas Nonprofit Health Corporation/501(a) Organization

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

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Whereas, To protect patients and physicians, Texas has a long history of restricting the corporate practice of medicine; and

Whereas, The Texas nonprofit health corporations (NPHCs)/501(a) organizations were created to address exceptional situations where nonphysician control of medical practices was in the greater public interest; and

Whereas, NPHCs/501(a) organizations are increasingly controlled by for-profit or effectively for-profit corporations violating the intent of the creation of the 501(a); therefore be it

RESOLVED, That the Texas Medical Association establish an ad hoc committee to study the effects of nonprofit health corporations (NPHCs)/501A organizations on the patients and physicians of Texas; and be it further

RESOLVED, That this ad hoc committee will generate recommendations based on its findings to educate and empower TMA to advocate effectively for needed changes in the statutes regulating NPHCs/501A organizations to protect the patients of Texas and the physicians who care for them.

Fiscal Note: $1,000

Related TMA Policy:

115.017 Protections of Non-employment Physicians Extended to 501 (a)s: The Texas Medical Association will work legislatively to ensure that institutions utilizing non-profit health corporations (NPHCs), formerly known as 501(a) organizations, be required to observe the following rules, as passed by the 82nd Texas Legislature in 2011, for institutions that employ physicians: (1) place the responsibility for all clinical matters – bylaws, credentialing, utilization review, and peer review – under the medical staff; (2) guarantee physicians' independent medical judgment; (3) state that all physicians – employed, part of a NPHC 501(a), or independent – are subject to the same rights and responsibilities; (4) allow physicians in NPHCs 501(a) entities to participate in the selection of their liability insurance and have the right to consent to settle in a liability action; and (5) require the medical staff to designate a chief medical officer (CMO) who must be approved by the NPHC hospital board. The CMO has the duty to report to the Texas Medical Board (TMB) that the hospital is utilizing physicians in NPHCs 501(a) entities and that the CMO is the contact with TMB. The CMO has a duty to report instances of interference to TMB (Amended Res. 404-A-12).

160.008 Nonprofit Health Corporations: An Ad Hoc Committee on Medical Practice Act, Section 162.001 (b), formerly known as 5.01(a), Nonprofit Health Corporations was appointed by the Texas Medical Association to study the issue. The following ad hoc committee recommendations for TMA rules

addressing board/member financial relationships, balance of financial powers, clinical practice, TMB surveillance, and education were reviewed and adopted with modification:

Board of Directors Selection

(1) The initial Board of Directors shall be appointed by the incorporating physician(s), but must be ratified by the participating physicians. Subsequent board members (or as an initial step, if there is a well-established physician body from the outset) shall be elected by the participating physicians (contracting and employed physicians) and may be ratified by the corporate member. (There should be a limit on the number of nominees on which the corporation member can "pass" before ratification, ie, the member must accept one from the first four presented.) If no participating physicians contract with the NPHC, employee physician election of board members would not be required. The physician board could reelect itself, subject to ratification by the corporate member.

(2) The term "actively engaged in the practice of medicine" shall mean the physician is primarily engaged in patient care as defined by the Medical Practice Act: the diagnosing, treatment, or offering to treat any mental or physical disease or disorder, or any physical deformity or injury, or performing such actions with respect to individual patients for compensation.

Board/Member Financial Relationship

If a physician board member has a financial tie or relationship with the corporation member, then such tie or relationship shall be disclosed at the time of nomination and election to the NPHC board and such tie or relationship shall be disclosed on the annual sworn statement to the TMB. Employees of the corporate member may not serve on the Board of Directors of the NPHC.

Balance of Financial Powers

All financial powers (budget, contracting, purchasing, etc.) shall be subject to board approval.

Clinical Practice

(1) Inclusion of the following language in the NPHC's bylaws. Nothing herein shall be construed as empowering the member, any officer, or employee of the member, or any nonphysician whatsoever, with the authority to interfere with the independent and professional practice of medicine by any director of the corporation or any participating physician (contracted or employed) of the corporation or to intervene in or interfere with the private doctor-patient relationship established between any patient and any director of the corporation or any participating physician (contracted or employed) of the corporation. All such physicians shall remain at all times free to exercise their independent clinical judgments on behalf of their patients, subject only to oversight by the authority of physician supervisors.

(2) The incorporating physician(s) may present the original bylaws, but the bylaws must be ratified by the physician board before they become effective. All subsequent bylaws and amendments shall be subject to board approval.

(3) The TMB draft regulations, section 177.1(b)(1), (4), and (7), dated Sept. 30 1994, concerning appointment and removal of board members, are adequate to address concerns about corporate member control and should be supported.

TMB draft regulations, Sections 177.1(b) (1), (4), and (7) are as follows:

(1) The organizing and incorporating physician(s) of the nonprofit organization shall select the initial board of directors consistent with the mission, goals, and purposes of the nonprofit organization.

(2) Subsequent to the appointment of the initial board of directors, a nonphysician member may not appoint or elect any director without the approval of at least a majority of the board of directors.

(3) The member may not remove a director during his or her term unless for cause consistent with the specific provisions of the bylaws of the nonprofit organization. Under no circumstances may the member remove a director either without cause or for any reason relating to credentialing, quality assurance, utilization review, peer review, or the practice of medicine.

(4) The TMB draft regulations Section 177.1(b)(6), dated Sept. 30, 1994, should be strengthened so that due process for participating physicians is required:

Section 177.1(b)(6). Any decision of the nonprofit organization to terminate the contract of any physician employed by or otherwise under contract to the nonprofit organization to provide medical services must be made exclusively by the board of directors or its physician designees and subject to the due process and appellate review process which shall be adopted by the board of directors and provided for in the contract between the nonprofit organization and the participating physician.

Texas Medical Board Surveillance

(1) Adoption of the following rules by the TMB: A Section 162.001 (b) formerly know as 5.01(a) NPHC shall, in June of each year, file with the TMB a sworn statement showing the name and address of the association, the names and addresses of all members of the association, and all officers and all members of the board of directors or trustees, and shall state that all board members are licensed to practice medicine and actively engaged in the practice of medicine in Texas. In addition, a copy of the current articles of incorporation and bylaws shall be filed, if not on file, and the financial report of the Section 162.001 (b), formerly known as 5.01(a) corporation and any corporate members also shall be filed as part of the annual report. Failure to file any such report may be grounds for involuntary revocation of the board's approval or certification under this chapter.

(2) The application and renewal fees charged by the TMB for Section 162.001 (b), formerly known as 5.01(a) NPHCs should be set at a price which approximates the costs of processing the application and renewal requests.

Education

TMA and TMB should develop educational information and programs on NPHCs. The program would include what they are, why they are being developed, and how they should be structured. Articles in Texas Medicine covering similar information also should be developed. A workshop at the TMA Annual Session and joint workshops with other concerned organizations on NPHCs also should be developed (Council on Legislation, p 92, I-94; reaffirmed CSE Rep. 3-A-04; amended CSE Rep. 2-A-14).

Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 107
A-18

Subject: Physician Protections When Reporting Violations of Nonprofit Health Corporations

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

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Whereas, Many physicians are becoming employed by nonprofit health corporations (NPHCs), formerly known as 501(a) organizations; and

Whereas, The Texas Medical Association has recognized for many years that physicians employed by NPHCs need to be protected against clinical intrusions; and

Whereas, The 82nd Texas Legislature added Section 162.0021 to the Texas Occupations Code that prohibits certified health organizations from interfering with, controlling, or otherwise directing a physician's professional judgment, and Section 311.063(g) of the Texas Health and Safety Code that establishes the chief medical officer (CMO) of the NPHC as the responsible party with duty to report to the Texas Medical Board; and

Whereas, Current Texas law does not adequately protect physicians who report violations of Section 162.0021 or other laws from retaliation by the NPHC; and

Whereas, Although current Texas law states that the CMO of the NPHC is the responsible party, the law does not, however, provide penalties for violating Section 162.0021; therefore be it

RESOLVED, That the Texas Medical Association develop legislation that forbids retaliation by a nonprofit health corporation (NPHC) against any person working for the NPHC who files a complaint or reports a suspected violation of state or federal law; and be it further

RESOLVED, That the Texas Medical Association develop model legislation, or ask the Texas Medical Board (TMB) to adopt rules providing TMB authority to accept, process, and dispose of complaints against a licensed NPHC through its board members and/or the chief medical officer.

Related TMA Policy:
115.017 Protections of Non-employment Physicians Extended to 501(a)s: The Texas Medical Association will work legislatively to ensure that institutions utilizing non-profit health corporations (NPHCs), formerly known as 501(a) organizations, be required to observe the following rules, as passed by the 82nd Texas Legislature in 2011, for institutions that employ physicians: (1) place the responsibility for all clinical matters – bylaws, credentialing, utilization review, and peer review – under the medical staff; (2) guarantee physicians' independent medical judgment; (3) state that all physicians – employed, part of a NPHC 501(a), or independent – are subject to the same rights and responsibilities; (4) allow physicians in NPHCs 501(a) entities to participate in the selection of their liability insurance and have the right to consent to settle in a liability action; and (5) require the medical staff to designate a chief medical officer (CMO) who must be approved by the NPHC hospital board. The CMO has the duty to report to the Texas Medical Board (TMB) that the hospital is utilizing physicians in NPHCs 501(a) entities and

that the CMO is the contact with TMB. The CMO has a duty to report instances of interference to TMB (Amended Res. 404-A-12).

160.008 Nonprofit Health Corporations: An Ad Hoc Committee on Medical Practice Act, Section 162.001 (b), formerly known as 5.01(a), Nonprofit Health Corporations was appointed by the Texas Medical Association to study the issue. The following ad hoc committee recommendations for TMA rules addressing board/member financial relationships, balance of financial powers, clinical practice, TMB surveillance, and education were reviewed and adopted with modification:

Board of Directors Selection -
(1) The initial Board of Directors shall be appointed by the incorporating physician(s), but must be ratified by the participating physicians. Subsequent board members (or as an initial step, if there is a well-established physician body from the outset) shall be elected by the participating physicians (contracting and employed physicians) and may be ratified by the corporate member. (There should be a limit on the number of nominees on which the corporation member can "pass" before ratification, ie, the member must accept one from the first four presented.) If no participating physicians contract with the NPHC, employee physician election of board members would not be required. The physician board could reelect itself, subject to ratification by the corporate member.
(2) The term "actively engaged in the practice of medicine" shall mean the physician is primarily engaged in patient care as defined by the Medical Practice Act: the diagnosing, treatment, or offering to treat any mental or physical disease or disorder, or any physical deformity or injury, or performing such actions with respect to individual patients for compensation.

Board/Member Financial Relationship -
If a physician board member has a financial tie or relationship with the corporation member, then such tie or relationship shall be disclosed at the time of nomination and election to the NPHC board and such tie or relationship shall be disclosed on the annual sworn statement to the TMB. Employees of the corporate member may not serve on the Board of Directors of the NPHC.

Balance of Financial Powers -
All financial powers (budget, contracting, purchasing, etc.) shall be subject to board approval.

Clinical Practice -
(1) Inclusion of the following language in the NPHC's bylaws. Nothing herein shall be construed as empowering the member, any officer, or employee of the member, or any nonphysician whatsoever, with the authority to interfere with the independent and professional practice of medicine by any director of the corporation or any participating physician (contracted or employed) of the corporation or to intervene in or interfere with the private doctor-patient relationship established between any patient and any director of the corporation or any participating physician (contracted or employed) of the corporation. All such physicians shall remain at all times free to exercise their independent clinical judgments on behalf of their patients, subject only to oversight by the authority of physician supervisors.
(2) The incorporating physician(s) may present the original bylaws, but the bylaws must be ratified by the physician board before they become effective. All subsequent bylaws and amendments shall be subject to board approval.
(3) The TMB draft regulations, section 177.1(b)(1), (4), and (7), dated Sept. 30 1994, concerning appointment and removal of board members, are adequate to address concerns about corporate member control and should be supported.

TMB draft regulations, Sections 177.1(b) (1), (4), and (7) are as follows:
(1) The organizing and incorporating physician(s) of the nonprofit organization shall select the initial board of directors consistent with the mission, goals, and purposes of the nonprofit organization.

(2) Subsequent to the appointment of the initial board of directors, a nonphysician member may not appoint or elect any director without the approval of at least a majority of the board of directors.

(3) The member may not remove a director during his or her term unless for cause consistent with the specific provisions of the bylaws of the nonprofit organization. Under no circumstances may the member remove a director either without cause or for any reason relating to credentialing, quality assurance, utilization review, peer review, or the practice of medicine.

(4) The TMB draft regulations Section 177.1(b)(6), dated Sept. 30, 1994, should be strengthened so that due process for participating physicians is required:
Section 177.1(b)(6). Any decision of the nonprofit organization to terminate the contract of any physician employed by or otherwise under contract to the nonprofit organization to provide medical services must be made exclusively by the board of directors or its physician designees and subject to the due process and appellate review process which shall be adopted by the board of directors and provided for in the contract between the nonprofit organization and the participating physician.

Texas Medical Board Surveillance -
(1) Adoption of the following rules by the TMB: A Section 162.001 (b) formerly known as 5.01(a) NPHC shall, in June of each year, file with the TMB a sworn statement showing the name and address of the association, the names and addresses of all members of the association, and all officers and all members of the board of directors or trustees, and shall state that all board members are licensed to practice medicine and actively engaged in the practice of medicine in Texas. In addition, a copy of the current articles of incorporation and bylaws shall be filed, if not on file, and the financial report of the Section 162.001 (b), formerly known as 5.01(a) corporation and any corporate members also shall be filed as part of the annual report. Failure to file any such report may be grounds for involuntary revocation of the board's approval or certification under this chapter.
(2) The application and renewal fees charged by the TMB for Section 162.001 (b), formerly known as 5.01(a) NPHCs should be set at a price which approximates the costs of processing the application and renewal requests.

Education -
TMA and TMB should develop educational information and programs on NPHCs. The program would include what they are, why they are being developed, and how they should be structured. Articles in Texas Medicine covering similar information also should be developed. A workshop at the TMA Annual Session and joint workshops with other concerned organizations on NPHCs also should be developed (Council on Legislation, p 92, I-94; reaffirmed CSE Rep. 3-A-04; amended CSE Rep. 2-A-14).

160.010 Employment by Nonprofit Corporations: The Texas Medical Association voted to educate physicians on the potential for their becoming effectively employed by hospitals, insurance companies, and others if they participate in the Section 162.001 (b), formerly known as 5.01(a) nonprofit corporation controlled by a hospital, insurance company, and others. TMA vigorously opposes the use of Section 162.001 (b) of the Texas Occupations Code, formerly known as 5.01(a) by hospitals and insurance companies as a means of circumventing the prohibition against the corporate practice of medicine (Res. 28EE, A-94; reaffirmed CSE Rep. 3-A-04; amended CSE Rep. 2-A-14).

165.007 Whistle-blower Protections for Physicians: The Texas Medical Association will undertake efforts including legislation to modify Texas law to establish protection from retaliation tactics for private contracting physicians and physician employees when they comply with reporting obligations and requirements to state and federal agencies (CM-PPA Rep. 1-A-10).

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).

Related AMA Policy:

Corporate Practice of Medicine H-215.981

(1) Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine. (2) At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs. (3) Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.

Fair Process for Employed Physicians H-435.942

1. Our AMA supports whistleblower protections for health care professionals and parties who raise questions that include, but are not limited to, issues of quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity. 2. Our AMA will advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace.

Sources:

1) Texas Occupations Code, Title 3. Health Professions, Subtitle B. Physicians, Chapter 162. Regulation of Practice of Medicine, Subchapter A. Regulation by Board of Certain Nonprofit Health Corporations Sec. 162.0021. INTERFERENCE WITH PHYSICIAN'S PROFESSIONAL JUDGMENT PROHIBITED. A health organization certified under Section 162.001(b) may not interfere with, control, or otherwise direct a physician's professional judgment in violation of this subchapter or any other provision of law, including board rules. Added by Acts 2011, 82nd Leg., R.S., Ch.670 (S.B.1661), Sec.1, eff. Sept. 1, 2011.
2) From the Texas Medical Board website: The Texas Occupations Code and Board Rules authorizes the Texas Medical Board to approve and certify two types of health organizations which meet certain strict criteria. Both types of nonprofit health organizations must keep TMB informed of changes in their by-laws and boards of directors, and must file detailed reports with TMB every two years to maintain their certification. Board Rules concerning nonprofit certification are found in Chapter 177 of the Board Rules. The first and most prevalent type is referred to in chapter 162.001(b) of the Texas Occupations Code. Characteristics:

- Is organized as nonprofit corporation
- Is organized for a purpose in the public interest, such as research, education or public health
- Must be incorporated and directed by physicians licensed by TMB
- Those physicians must be actively engaged in the practice of medicine
- The administrative side of the corporation may be handled by non-physician officers, but all medical decisions and the overall medical policies of the organization must be made by physicians.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 108
A-18

Subject: Inclusion of Medical Students in Good Samaritan Laws and Policies for Disaster Settings

Introduced by: Medical Student Section

Referred to: Reference Committee on Financial and Organizational Affairs

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Whereas, The demand for medical practitioners exceeded the availability of licensed physicians and other licensed health care workers during Hurricane Harvey; and

Whereas, Almost 65 percent of matriculating medical students surveyed in 2017 reported service during times of crisis or for social change as very important or essential to their career in medicine; and

Whereas, First-year medical students possess competency in triage systems, which can be useful in a disaster situation; and

Whereas, The Texas Medical Association previously supported the Good Samaritan law as it applies to physicians and licensed practitioners; and

Whereas, The Texas Good Samaritan law ensures that emergency medical service personnel who are not licensed or certified in the healing arts who administer emergency care in good faith are not liable for civil damages unless the act was willfully or wantonly negligent; therefore be it

RESOLVED, That the Texas Medical Association support medical students volunteering outside of their institutional affiliations during times of disaster and emergency, due to both the need for and the competency of medical students, as demonstrated by previous research and disaster situations; and be it further

RESOLVED, That the Texas Medical Association study the involvement of medical students in natural disaster and emergency situations; and be it further

RESOLVED, That the Texas Medical Association support the Good Samaritan law in application to medical students as unlicensed providers of care in emergency settings, due to both the need for medical students in disaster situations and the lack of protection afforded to them under current Texas law.

Related TMA Policy:
170.001 Good Samaritan and Charitable Immunity Laws: The Texas Medical Association continues to support the Good Samaritan Law, that allows persons including physicians, to render aid in an emergency free from liability when it is not provided for or in expectation of compensation. The Texas Medical Association continues to support the Charitable Immunity Law which allows any health care provider who voluntarily provides medical or health care to the needy free of charge to be free of liability risks. These laws allow semi-retired and retired health care professionals to participate in providing health care to those in need without having to purchase professional liability insurance. TMA continues to support legislative efforts to dissolve road blocks to access to medical care by the needy (Res. 27DD, p 181K, I-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

Related AMA Policy:

Delivery of Health Care by Good Samaritans H-130.937

1. Our AMA will work with state medical societies to educate physicians about the Good Samaritan laws in their states and the extent of liability immunity for physicians when they act as Good Samaritans.
2. Our AMA encourages state medical societies in states without "Good Samaritan laws," which protect qualified medical personnel, to develop and support such legislation.
3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, the AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, "bystander physicians" shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician relationships, to those in need of medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. (a) Bystander physicians should recognize that prehospital EMS systems operate under the authority and direction of a licensed EMS physician, who has both ultimate medical and legal responsibility for the system. (b) A reasonable policy should be established whereby a bystander physician may assist in an emergency situation, while working within area-wide EMS protocols. Since EMS providers (non-physicians) are responsible for the patient, bystander physicians should work collaboratively, and not attempt to wrest control of the situation from EMS providers. (c) It is the obligation of the bystander physician to provide reasonable self-identification. (d) Where voice communication with the medical oversight facility is available, and the EMS provider and the bystander physician are collaborating to provide care on the scene, both should interact with the local medical oversight authority, where practicable. (e) Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that he/she will take responsibility for the patient(s), including provision of care during transportation to a medical facility. Medical oversight systems lacking voice communications capability should consider the addition of such communication linkages to further strengthen their potential in this area. (f) The bystander physician should avoid involvement in resuscitative measures that exceed his or her level of training or experience. (g) Except in extraordinary circumstances or where requested by the EMS providers, the bystander physician should refrain from providing medical oversight of EMS that results in deviation from existing EMS protocols and standing orders.
4. Our AMA urges the International Civil Aviation Organization to make explicit recommendations to its member countries for the enactment of regulations providing "Good Samaritan" relief for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations.

Sources:

1. Fink, S., & Blinder, A. (2017, August 28). Houston's Hospitals Treat Storm Victims and Become Victims Themselves. www.nytimes.com/2017/08/28/us/hurricane-harvey-houston-hospitals-rescue.html. Retrieved Feb. 16, 2018.
2. Matriculating Student Questionnaire (MSQ) — Data and Analysis — AAMC. (2017) www.aamc.org/data/msq/. Retrieved March 02, 2018.
3. Jorm, C., Roberts, C., Lim, R., Roper, J., Skinner, C., Robertson, J., & Osomanski, A. (2016). A large-scale mass casualty simulation to develop the non-technical skills medical students require for collaborative teamwork. *BMC Medical Education,* 16(1), 83.
4. Texas Medical Association. Policy Compendium. Policy 170.001.
5. Tex. Civ. Prac. & Rem. Code § 74.152.

Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 109
A-18

Subject: Liability Exemptions for Volunteer Medical Health Workers

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

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Whereas, Medical volunteers are critical to any community's emergency response; and

Whereas, Because of numerous unworkable conditions in existing Texas law, the clear majority of physicians who volunteer to provide medical services during a disaster are protected against tort claims only by their own liability policy; and

Whereas, Liability policies throughout the state vary greatly in the restrictions they place on volunteer activities and as a result, many volunteer responders unknowingly have no liability protection; and

Whereas, Physicians and other medical volunteers who are asked to respond to an emergency should not have to stop to consult a legal document before responding; and

Whereas, Governmental entities in Texas are empowered to extend liability protection to medical volunteers who respond to a call for help; therefore be it

RESOLVED, That the Texas Medical Association develop legislation that establishes a statewide medical liability exemption for medical health workers who respond to a call for medical volunteers from a state or local governmental or medical entity.

Related TMA Policy:
170.001 Good Samaritan and Charitable Immunity Laws: The Texas Medical Association continues to support the Good Samaritan Law, that allows persons, including physicians, to render aid in an emergency free from liability when it is not provided for or in expectation of compensation. The Texas Medical Association continues to support the Charitable Immunity Law which allows any health care provider who voluntarily provides medical or health care to the needy free of charge to be free of liability risks. These laws allow semi-retired and retired health care professionals to participate in providing health care to those in need without having to purchase professional liability insurance. TMA continues to support legislative efforts to dissolve road blocks to access to medical care by the needy (Res. 27DD, p 181K, I-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

170.002 Charitable Immunity: The Texas Medical Association favors extending liability protections of the Texas Charitable Immunity and Liability Act of 1987 to physicians acting as direct-service volunteers on behalf of city, county, and state health departments, as well as those who volunteer services in local, state, or federally owned health care facilities, and voted to seek amendment of that law (Res. 28HH, p 207, A-92; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

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).

Related AMA Policy:

Immunity from Professional Liability Tort for Volunteer Services During State or National Emergencies H-435.958

The policy of the AMA is to formulate and support federal legislation granting legal immunity, including medical liability immunity, for volunteer medical services arising from declared state or national emergencies.

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.

Delivery of Health Care by Good Samaritans H-130.937

1. Our AMA will work with state medical societies to educate physicians about the Good Samaritan laws in their states and the extent of liability immunity for physicians when they act as Good Samaritans.
2. Our AMA encourages state medical societies in states without "Good Samaritan laws," which protect qualified medical personnel, to develop and support such legislation.
3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, the AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, "bystander physicians" shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician relationships, to those in need of medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. (a) Bystander physicians should recognize that prehospital EMS systems operate under the authority and direction of a licensed EMS physician, who has both ultimate medical and legal responsibility for the system. (b) A reasonable policy should be established whereby a bystander physician may assist in an emergency situation, while working within area-wide EMS protocols. Since EMS providers (non-physicians) are responsible for the patient, bystander physicians should work collaboratively, and not attempt to wrest control of the situation from EMS providers. (c) It is the obligation of the bystander physician to provide reasonable self-identification. (d) Where voice communication with the medical oversight facility is available, and the EMS provider and the bystander physician are collaborating to provide care on the scene, both should interact with the local medical oversight authority, where practicable. (e) Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that he/she will take responsibility for the patient(s), including provision of care during transportation to a medical facility. Medical oversight systems lacking voice communications capability should consider the addition of such communication

linkages to further strengthen their potential in this area. (f) The bystander physician should avoid involvement in resuscitative measures that exceed his or her level of training or experience. (g) Except in extraordinary circumstances or where requested by the EMS providers, the bystander physician should refrain from providing medical oversight of EMS that results in deviation from existing EMS protocols and standing orders.

4. Our AMA urges the International Civil Aviation Organization to make explicit recommendations to its member countries for the enactment of regulations providing "Good Samaritan" relief for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations.

Liability Protection for Medical Volunteers H-435.976

It is the policy of the AMA to endorse the concept of liability protection for medical volunteer services and to promote legislative efforts to achieve that goal.

Revised for Supplement
Items in Supplement are in italics.
Distributed at Meeting

AGENDA
REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HEALTH CARE QUALITY
Friday, May 18, 2018
JW Marriott San Antonio Hill Country Resort, Level 2, Cibolo Ballroom 8

1. Council on Health Care Quality Report 2 – Policy Review

2. Council on Medical Education Report 2 – Policy Review

3. Council on Medical Education Report 3 – Aligning Future Graduate Medical Education Capacity With Target Enrollments of New Texas Medical Schools

4. Council on Medical Education Report 4 – Physician Representation on Texas Higher Education Coordinating Board

5. Committee on Continuing Education Report 2 – Policy Review

6. Committee on Physician Distribution and Health Care Access Report 2 – Policy Review

7. Council on Practice Management Services Report 1 – Reducing Errors in Pharmacy (Resolution 307-A-17)

8. Council on Practice Management Services Report 2 – HIT Policy Review and New Cyber Security Policy

9. Resolution 201 – Incorporating High-Value Care into Undergraduate and Graduate Medical Education in Texas (Medical Student Section)

10. Resolution 202 – Addressing Gender Bias in Undergraduate Medical Education with Implicit Bias Training (Medical Student Section)

11. Resolution 203 – Freedom from Maintenance of Certification (Ori Z. Hampel, MD)

12. *Resolution 204 – Creating a Non-Profit Texas Board of Medical Specialties (Smith County Medical Society)*

13. *Resolution 205 – Graduate Associate Physicians (International Medical Graduate Section)*

REPORT OF COUNCIL ON HEALTH CARE QUALITY

CHCQ Report 2-A-18

Subject: Policy Review

Presented by: Ghassan F. Salman, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

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Every 10 years, TMA reviews its policies for relevance and appropriateness. The Council on Health Care Quality reviewed policy 225.010 Texas Medical Foundation as QIO, and the council recommends to amend and retain the policy as follows:

225.010 ~~**Texas Medical Foundation**~~ **TMF Health Quality Institute as QIO**: The Texas Medical Association ~~reaffirmed its~~ support<u>s</u> ~~for~~ the ~~Texas Medical Foundation~~ TMF Health Quality Institute to be the statewide Quality Improvement Organization (QIO) for Texas~~, and pledged its support and cooperation only to the Texas Medical Foundation to be the QIO for Texas~~.

~~The Texas Medical Association voted to pursue reasonable regulatory and statutory remedies to designate the Texas Medical Foundation as the sole organization in the state to do peer review for all health care programs in the state which are either fully or partially funded by federal dollars.~~

~~The Texas Medical Association supports and endorses the Texas Medical Foundation as the sole quality improvement and independent peer review organization for state and federal programs with the understanding that TMF will always provide due process~~ (Council on Socioeconomics, p 144, A-93; reaffirmed CSE Rep. 5-I-01; CSE and COL Rep. 1-A-02; Res. 28C, p 149, A-91; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 1-A-08).

Recommendation: Retain as amended.

REPORT OF COUNCIL ON MEDICAL EDUCATION

CME Report 2-A-18

Subject: Policy Review

Presented by: Steven R. Hays, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

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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 dated 2008 are summarized in this report.

The following policies are recommended for retention:

30.026 **Use of Professional Titles by Unlicensed Physicians:** A licensed physician who delegates medical acts to an unlicensed individual should assure that there are no misleading communications to patients that denote or connote licensure when such person is not licensed by the State of Texas. Graduates of medical schools who are not licensed to practice medicine by the Texas Medical Board and who are employed in some capacity in the health care field should become completely familiar with the Texas Medical Practice Act and appropriate insurance billing codes for nonphysician personnel. TMA, in conjunction with the Texas Hospital Association, voted to develop and recommend policy to a nongovernmental entity or entities (such as an employer) to (a) review and verify credentials and documentation of individuals not licensed to practice medicine, and (b) conduct a background check on individuals regarding appropriate professional issues. A licensed physician who delegates medical acts to an unlicensed individual should assure that such individual avoid use of terms or identifiers that connote licensure, such as doctor, MD, or DO, for the purposes of billing for such acts (Council on Medical Education, p 89-90, A-98; amended CM-PDHCA Rep. 2-A-08).

85.011 **Palliative Care:** TMA (1) urges Texas medical schools to periodically assess the adequacy of their curricular content in preparing medical students and residents to respond to the special needs of patients requiring palliative care with the goals of maintaining the highest quality of life possible during the final stages of life and preparing physicians for clinical and ethical issues related to end-of-life care; and (2) encourages availability of CME courses on the clinical and ethical issues related to end-of-life care (Amended CME Rep. 2-I-98 and Sub. Res. 201-I-98; amended CME Rep. 1-A-08).

200.027 **Graduate Medical Education Training Positions:** TMA supports the right of each GME program to select the best qualified candidates to fill available training positions (Board of Trustees, p 20, A-96; reaffirmed CME Rep. 1-A-08).

205.016 **Medical School Scholarships for Minorities:** TMA encourages scholarships for underrepresented minorities (Council on Medical Education, p 91, A-98; reaffirmed CME Rep. 1-A-08).

205.017 **Formula Funding for Health Science Centers:** TMA reaffirms its policy that Texas medical schools should be funded at a level that would allow them to continue to provide excellence in medical education, research, and patient care for Texas and encourages the Texas Legislature to take into account the amount of state funds that receive matching private

or federal grant funds in its allocation of state appropriations. TMA supports a fair and equitable state formula funding process for medical schools in the state that takes into account the unique mission and financial characteristics of each institution (Amended CME Rep. 3-I-98; amended CME Rep. 1-A-08).

205.028 **Mental Hospital Psychiatry Residency Training:** TMA endorses restoration or addition of sufficient funding for the involvement of state hospitals in the training of future psychiatrists and other mental health professionals (Amended Res. 307-A-08).

Recommendation 1: Retain.

The council recommends a general updating of these policies to reflect current views on physician workforce planning and to offer recommended changes in state medical school admission policies.

185.014 **Physician Workforce**: ~~TMA approved recommendations from 1996 data submitted by the Special Committee on the Texas Physician Workforce:~~ TMA supports efforts to maintain a high-quality medical education system and prepare physicians to meet the state's medical needs.

~~(1) A state-targeted ratio of 50 percent primary care and 50 percent nonprimary care physicians and a maintenance of the Texas physician workforce targeted at a physician-to-physician ratio of 158 physicians (79 primary care and 79 nonprimary care) per 100,000 population.~~

TMA continues to have policy in support of a strong primary care physician workforce; however, the previous goal of 50 percent primary care and 50 percent nonprimary care is no longer used as the goal for primary care at national or state levels.

(~~2~~1) Existing appropriations rider language that requires a minimum class size for Texas medical schools should be eliminated.

~~(2) The state could modify existing appropriations rider language that establishes a ceiling for nonresident enrollment in public medical schools. Adjusting the 10 percent ceiling downward would provide more medical school positions that could be filled by qualified Texas applicants.~~

(2) Texas medical schools should have greater flexibility in admitting non-Texas residents (as defined by state residency laws) each year, depending on the applicant pool. This would allow each medical school the discretion to admit an additional 1 percent to 5 percent highly qualified non-Texas residents each year above the current 10-percent limit. The requirement could be made that the additional non-Texas resident students should have a high probability of remaining in the state for residency training and entrance into practice.

TMA supports the use of eligibility criteria, such as the following, by the medical schools in selecting the additional non-Texas residents:

(a) Students who previously completed educational programs in Texas but lost Texas residency status prior to medical school,
(b) Students who have immediate family members in Texas,
(c) Qualified minority students who are underrepresented in medicine who could help increase diversity in Texas medical schools, and
(d) Students willing to commit to a Texas rural practice program or to residency training in Texas.

TMA should advocate for these changes to the Texas Legislature. If implemented, the impact of this special provision should be evaluated by TMA after five years for the purposes of determining whether this policy should be retained for an additional five years.

The Texas Legislature imposes a cap of 10 percent per year for the enrollment of non-Texas residents in medical schools. This restriction is included in the State Appropriations Act for each biennial state budget and is in effect for the two years of the budget. Several Texas medical schools reported to the council they believe it is in the best interest of the state to allow each school more flexibility in the enrollment of non-Texas residents each year, dependent on the school's individual applicant pool.

Some years, Texas medical schools turn away highly qualified applicants for the sole reason that they are not Texas residents. In many cases, this includes students who had formerly qualified as Texas residents but lost that status. Admission deans stressed their interest in admitting more highly qualified minority students who are non-Texas residents to improve the diversity of Texas medical schools. The deans emphasized that the unique perspectives and varied educational experiences of non-Texas residents bring a greater educational exchange to the state that can enrich the educational experience for all students.

The proposed 1-percent to 5-percent annual flexibility would have a minimal impact on admission numbers. For a typical medical school with a class size of 200, the flexibility provision could add two to 10 non-Texas resident students a year. Texas residents would continue to receive the highest priority in the application process. The 1-percent to 5-percent flexibility in admissions policies for non-Texas residents would be voluntary.

(3~~4~~) Texas medical schools should continue to be funded at a level that would allow them to continue to provide excellence in medical education, research and patient care for Texans.

(4~~5~~) Career counselors at undergraduate college and high school levels should be informed of any changes that may occur in class sizes and the applicant pools for Texas medical schools as well as the market demand for physicians.

(5~~6~~) Career counselors at the undergraduate college level should be informed of any significant changes that may occur in the number of first-year positions, market opportunities, funding sources, or other factors that could negatively affect Texas GME programs, and subsequently reduce the opportunities for IMGs seeking to enroll in a US GME program.

~~(7) The Texas Legislature should fund Texas GME programs that are currently being supported through teaching hospital and medical school funds to cover the state's share of the cost of GME and to replace the lost practice plan funds with general revenue.~~

The reference to "lost practice plan funds" is not clear, and the council recommends deletion of this statement.

~~(8) Texas GME programs that receive these additional state funds should develop incentive programs for their residents.~~

This statement is vague, and the council recommends deletion.

(6~~9~~) Texas GME programs are encouraged to assign a high priority to ~~TXMGs~~ Texas medical school graduates and ~~USMGs~~ U.S. medical school graduates to fill training positions within their programs.

(7~~10~~) Texas GME programs should continue to regularly adjust the number and mix of first-year positions ~~regularly~~ based on the most current physician workforce and population health

status data (Board of Trustees, p 39C, I-96; amended CME Rep. 4-A-01; amended CME Rep. 1-A-08).

205.011 **Student and Resident Economic Hardship**: TMA ~~voted to continue to educate~~ supports the continued education of elected officials and philanthropic organizations regarding the importance to Texas medical students and residents of a broad definition of economic hardship for the purposes of qualifying for education-related scholarships and loans (Medical Student Section, p 195, I-94; reaffirmed CME Rep. 1-A-08).

205.018 **Hopwood v. Texas**: The impact of *Hopwood v. Texas* has had a negative effect on underrepresented minorities in Texas medical schools, and TMA~~,~~ therefore~~,~~ supports efforts to reverse this negative effect, understanding that specific measures of support will be acted on individually as they arise in the future. TMA supports continuation of the minority scholarship program for underrepresented minority students ~~and~~ at Texas medical schools to offset the void of such scholarships at Texas institutions and an increase in the amount of the individual scholarships as funds become available (BOT Rep. 20-I-98; amended CME Rep. 1-A-08).

245.016 **Physician Reentry Into Practice**: The Texas Medical Association recognizes the potential societal as well as personal benefits to be gained from a process that facilitates the reentry of qualified physicians to medical practice following an extended break from professional practice, defined as at least two years, rather than prematurely ending their medical careers and forfeiting their potential contributions to medical care. To assist physicians with the reentry process:

TMA encourages the Texas Medical Board to use a system that provides a case-by-case, individualized skills assessment of physicians seeking reentry into medical practice.

TMA supports programs designed to facilitate a physician's reentry into practice by removing barriers faced in returning to practice, including:

(a) Program(s) that provide individualized assessments of a physician's readiness to reenter practice, including identification of potential deficiencies in a physician's qualifications for reentry and remediation or retraining needs;

(b) Programs or availability of materials to assist physicians in conducting a self-assessment of readiness to return to practice; ~~and~~

(c) Process for providing remediation and retraining resources to address a physician's individual needs as identified through an assessment process~~.~~; and

(d) Availability of affordable professional liability coverage for physicians enrolled in reentry programs such as KSTAR (Knowledge, Skills, Training, Assessment, and Research) at the Texas A&M University Health Science Center A&M Rural and Community Health Institute, and other physician remediation and retraining programs.

The council became aware that Texas Medical Liability Trust (TMLT) writes three-month liability coverage policies for physicians who are enrolled in the KSTAR reentry programs. This coverage is critically important for allowing physicians to be engaged in patient care during the remediation and retraining processes. The council recommends a reference be added to the policy statement to recognize the availability of professional liability coverage for participants in these reentry programs.

TMA applauds the initiative taken by programs such as KSTAR (~~Knowledge, Skills, Training, Assessment, and Research) at the Texas A&M Health Science Center Rural and Community Health Institute~~, as well as the physician remediation and retraining programs at ~~John Peter Smith Hospital in Fort Worth and~~ UT Health San Antonio, The University of Texas Medical Branch at Galveston, and similar programs. Each of these programs voluntarily took the initiative to fill the void of resources available to physicians seeking reentry into practice, and these programs serve as exemplary examples of inter-institutional collaboration.

The council recommends minor edits for updating purposes.

Texas medical schools are encouraged to consider whether they can play a role in responding to the retraining needs of physicians seeking reentry into practice in their individual regions of the state, including the provision of mini-residencies.

TMA supports a process for identifying and training physicians to serve as mentors for assisting in monitoring the medical practices of physicians during the early stages of reentry into practice, possibly including a review of medical records and other measures that assess adherence to established standards of care. Monitors should be board certified in the same specialty or subspecialty as the physician being mentored. Further, TMA pledges its willingness to assist the Texas Medical Board in developing any necessary rules or procedures for establishing such a monitoring program.

TMA recognizes that the ability of physicians to utilize assessment and retraining programs is contingent on the accessibility and affordability of such programs.

Physicians who plan to take a break from practice and allow their medical licenses to lapse are encouraged to consider the long-term effects and potential barriers they may face should they decide to return to active practice in the future. Further, the Texas Medical Board is encouraged to fully inform physicians at the time of initial licensure as well as renewal of the potential challenges that may be faced should a physician allow his or her Texas medical license to lapse, then seek reentry into medicine after more than two years. The Texas Medical Association also should take steps to inform Texas physicians of these potential challenges to reentry.

TMA supports greater promotion and awareness of existing resources to help physicians seeking reentry into practice. Further, TMA encourages periodic evaluation of the impact of physician reentry into practice assessment and retraining programs, and continued monitoring of their effectiveness (CME Rep. 2-A-08).

Recommendation 2: Retain as amended.

REPORT OF COUNCIL ON MEDICAL EDUCATION

CME Report 3-A-18

Subject: Aligning Future Graduate Medical Education Capacity With Target Enrollments of New Texas Medical Schools

Presented by: Steven R. Hays, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

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State Senate Bill 1066, authored by Sen. Charles Schwertner, MD (R-Georgetown), and passed into law by the 2017 Texas Legislature, requires new medical schools applying for approval by the Texas Higher Education Coordinating Board to submit simultaneously a plan for ensuring there are an adequate number of residency positions in the state for the projected graduates. Changes are needed, however, for the new law to meet the original intent. New medical schools are required to submit such a plan only for the number of students in the *inaugural* class. Most schools, however, start out with a relatively small number in the inaugural class, with plans to expand the class size after achieving full accreditation status after four years. This means new medical schools are not required to plan for the graduate medical education (GME) needs of their target enrollment. This defeats the objective of the legislation.

Examples:

- Texas Tech University Health Sciences Center Foster Medical School in El Paso started with 40 students in 2009 and now has a class size of 103 (158 percent rate of growth).
- University of North Texas Health Science Center/Texas Christian University Medical School in Fort Worth reported plans to start with 60 in 2019 and grow to 240 (300 percent rate of growth).
- University of Houston Medical School plans to open with a class size of 30 in 2020 and expand to 120 in 2024 (300 percent rate of growth).

The council believes the state law resulting from the passage of SB 1066 should be amended to better align the law with the goal of planning for the full GME needs of future Texas medical school graduates. This would help enable more Texas graduates to remain in the state for residency and likely yield a better return on the state's annual investment of at least $45,000 per medical student.

The council recognizes that private medical schools are not required to obtain state approval to open a medical school in Texas and are exempt from the GME planning requirements resulting from SB 1066. Nevertheless, the council feels it is in the best interest of the state that any medical school operating in the state, public or private, should plan for the GME needs of its graduates, in keeping with the spirit of SB 1066.

Recommendation: The council recommends approval of the following as Texas Medical Association policy for Aligning Future Graduate Medical Education Capacity With Target Enrollments of New Texas Medical Schools

1. TMA supports an amendment to state law that would stipulate that public medical schools are required to submit a plan to meet the graduate medical education (GME) needs for the school's planned target class size. The GME plan is to be submitted to the Texas Higher Education Coordinating Board as part of its application for approval to offer a program leading to an MD or DO degree.

If at any time a medical school substantially increases its class size after approval from the Texas Higher Education Coordinating Board to offer a program leading to an MD or DO degree, the Texas Medical

Association believes the medical school then should be required to provide an updated GME plan to the board that reflects the subsequent increase in class size. TMA believes the board should make a determination as to what constitutes a substantial increase in class size for the purposes of this reporting requirement.

2. TMA believes it is in the best interest of the state that any medical school operating in the state, public or private, should plan for the GME needs of its graduates and that its plans should focus on the GME capacity needed for the school's target class size.

REPORT OF COUNCIL ON MEDICAL EDUCATION

CME Report 4-A-18

Subject: Physician Representation on Texas Higher Education Coordinating Board

Presented by: Steven R. Hays, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

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The Texas Higher Education Coordinating Board is the state agency with responsibility for approving new public medical schools and other proposed health professions educational programs. In addition, this agency administers the state's graduate medical education (GME) expansion grant programs and other important GME programs, including family medicine residency grants and primary care preceptorships. This agency also has the authority to disburse loan repayment to physicians through the State Physician Education Loan Repayment Program and Loan Repayment Program for Mental Health Professionals. This agency is influential in determining the amount of state funding needed for these programs and determining how funds are distributed to program participants.

Despite this high level of oversight of programs that impact physicians, the representation of physicians on this agency's governing board has been inconsistent. Before the appointment of David Teuscher, MD, in 2011, there was an extended period when no physicians served on the board. During this gap, in 2006, the agency approved programs such as the doctor of nursing practice degree programs for advanced practice registered nurses. This degree program generated considerable concerns among Texas physicians. When a physician representing TMA attended a board meeting in 2006 at a time when this degree program was being considered for adoption, she was not allowed the opportunity to express these concerns through public testimony. Had a physician been on the board at that time, the council believes this likely would not have happened.

Once again, at this writing there are no physicians appointed to the Texas Higher Education Coordinating Board. Given the level of authority this agency has to approve new medical schools and other health professions programs of high importance to medicine, as well as the board's key role in the distribution of state funding for medical education, graduate medical education, physician loan repayment, and other health professions programs, the council strongly supports a consistent physician representation on this agency's governing board.

Recommendation: The council recommends approval of the following as Texas Medical Association policy:

Physician Representation on the Texas Higher Education Coordinating Board: Recognizing the influential role of the Texas Higher Education Coordinating Board in the development and funding of new medical schools and other health professions programs in the state, the Texas Medical Association strongly supports the appointment of at least one if not more physicians to the Texas Higher Education Coordinating Board and policies that would prevent extended gaps in physician representation.

REPORT OF COMMITTEE ON CONTINUING EDUCATION

CM-CE Report 2-A-18

Subject: Policy Review

Presented by: Aurelio Matamoros, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

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TMA periodically reviews House of Delegates policies in the association's Policy Compendium for relevance and appropriateness. The committee reviewed three policies and offers the following recommendations:

The following policies are recommended for retention as amended:

70.004 **CME Commercial Support:** In keeping with its CME mission, the Texas Medical Association shall provide CME activities which serve to improve the physician's ability to provide appropriate and high quality medical care to the people of Texas. To fully accomplish this goal, all CME activities ~~sponsored~~ provided and jointly ~~sponsored~~ provided by TMA shall fully comply with the Standards for Commercial Support, Standards to Ensure Independence in CME Activities, as set forth by the Accreditation Council for Continuing Medical Education. Therefore, it is TMA's policy that the association maintain full control over the content, quality, and scientific integrity of all activities certified for continuing medical education credit. This control extends to assessment and prioritizing of physician CME needs, development of education objectives and methodology, selection of content and faculty, evaluation procedures, and funding options.

CME presentations must provide an unbiased view of therapeutic options, efficacy, and risk factors. Use of generic names is encouraged. If one product trade name is used, then all trade names of mentioned products should be used. When commercial exhibits or social activities are part of an overall program, such activities shall be placed apart from the educational activities and implemented in a manner that will neither interfere with, nor take precedence over, educational activities.

TMA requires that medical industry subsidies be submitted in the form of a general educational grant for the activity. All financial support shall be provided with full knowledge and approval of TMA. Placement of exhibits shall not be a condition of support for any TMA CME activity.

TMA will not ~~sponsor~~ provide or jointly ~~sponsor~~ provide activities for which physicians receive payment, substantial gifts, or expense reimbursement from medical industry to attend.

Commercial subsidies for modest meals or social events planned by TMA as part of the activity are permitted within reason. Likewise, speakers may receive responsible honoraria and expense reimbursement paid in accordance with TMA's Policy on Faculty Honoraria for CME Activities.

Scholarship or other special funding to permit medical students, residents, or fellows to attend selected education conferences may be provided, as long as the selection of students,

residents, or fellows who will receive the funds is made by either the academic or training institution or the accredited ~~sponsor~~ provider, acting with the concurrence of the other (Committee on Continuing Education, p 100-101, I-92; reaffirmed CM-CE Rep. 1-A-03; amended CME Rep. 4-A-08).

70.007 **CME Mission Statement:** Following is the Texas Medical Association's continuing medical education mission statement:

PURPOSE OF CME PROGRAM
To facilitate physician access to quality continuing medical education, including effective use of technology, through TMA's accredited CME program and its intrastate CME accreditation program. The activities provided by TMA's CME program will address the professional practice gaps of physician learners as identified in their scope of practice and professional requirements.

TARGET AUDIENCE
Activities implemented through the CME program will seek to serve all Texas physicians with an emphasis on meeting specific regional needs of physicians practicing in educationally underserved areas of Texas. Although TMA's CME program primarily will serve Texas physicians, some activities may be extended to a national audience when justified by appropriate needs assessment and topic.

CONTENT
TMA seeks to improve Texas physicians' expertise in practicing the art and science of medicine through educational activities in the following areas:

Prevention, detection, and treatment of disease and health concerns including public health threats, cancer, and end-of-life care;

Quality improvement, liability risk reduction, and enhancement of the practice environment;

Impaired physician awareness, preventive measures, and appropriate treatment;

Ethics and professional responsibility education;

Physician leadership topics including legislative and regulatory issues and communication skills.

TYPES OF ACTIVITIES AND SERVICES
The CME program will utilize formats for learning that will include interactivity of the teacher and learner to the degree possible. Activities and services offered are as follows:

Annual meeting with multiple educational sessions;

Statewide and regional seminars;

Enduring materials for independent study, including use of the Internet;

Joint ~~sponsorship~~ providership;

Outreach (taking AMA PRA-Cat. 1- approved activities and speakers to local areas upon request).

To provide learning opportunities beyond those TMA can directly sponsor, TMA will maintain an intrastate CME accreditation program through the Accreditation Council for CME to grant CME accreditation to organizations in Texas serving Texas physicians.

EXPECTED RESULTS OF CME PROGRAM

It is expected that Texas physicians will be able to access quality CME to meet their requirements for practice updates, license renewal, and various certifications. This CME will improve physicians' competence or performance in practice, thereby supporting TMA's Vision, *To improve the health of all Texans*. Change in competence will be evaluated with immediate post-activity evaluation forms and/or audience response technology. Change in physician performance will be self-reported by physician learners at an appropriate time interval after the activity. Data gathered from these evaluation processes will enable the Committee on Continuing Education to determine the effectiveness of the overall CME program to address identified practice gaps (CM-CE Rep. 4-I-98; revised CM-CE Rep. 1-A-03; amended CME Rep. 4-A-08).

70.009 **Conflict of Interest, CME Activities:** It is the policy of the Texas Medical Association that its continuing medical education programming not be influenced by the special interests of anyone associated with the activities it ~~sponsors~~ provides and jointly ~~sponsors~~ provides. Therefore, it is expected that continuing medical education faculty, program planners, consultants, and other individuals associated with the development and implementation of the association's activities forthrightly disclose all relevant financial relationships of any amount in the past 12 months with any commercial interest that may create a conflict of interest relative to their role in the activity. Such disclosure should be made in writing to the Committee on Continuing Education, which will evaluate the potential conflict prior to the activity and determine appropriate action. Potential conflicts of interest shall not automatically disqualify an activity or speaker. Such conflicts, however, shall be resolved and always fully disclosed through appropriate statements in the activity's promotional material or in moderator or faculty remarks at the beginning of the activity. Any individual who refuses to disclose relevant financial relationships cannot participate as a planner, teacher, or author of CME activities (Reaffirmation of 1991 policy in lieu of Res. 29AA, p 161E, A-98; amended CME Rep. 4-A-08).

Recommendation: Retain as amended.

REPORT OF COMMITTEE ON PHYSICIAN DISTRIBUTION AND HEALTH CARE ACCESS

CM-PDHCA Report 2-A-18

Subject: Policy Review

Presented by: Marco Uribe, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

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TMA periodically reviews House of Delegates policies in the association's Policy Compendium for relevance and appropriateness. The committee's analysis and recommendations for retention, deletion, or amendments of policies dated 2008 are summarized in this report.

The following policy is recommended for retention:

55.027 **Public School Education:** With the goal of improving the public school system through active participation, TMA members are encouraged to become involved with the public school system in their areas to the degree possible, including mentoring students and joining in community/school partnership programs, where available. In addition, TMA encourages its members to work with local school systems to establish advanced placement and enrichment programs in mathematics and science, with special emphasis on encouraging participation of disadvantaged students in these programs (Council on Medical Education, p 92, A-98; reaffirmed CM-PDHCA Rep. 2-A-08).

Recommendation 1: Retain.

The following policy is recommended for retention with changes:

290.005 **Telemedicine:** The Texas Medical Association ~~supports the use of telecommunications in clinical proctoring and training of physicians, nurses, and allied health personnel within current standards for higher education, undergraduate and graduate medical education, preceptorships, and continuing medical education.~~

~~TMA~~ defines telemedicine as clinical and diagnostic services delivered via telecommunications technology; the use of telecommunication technology to facilitate health care delivery; the application of telecommunications and information resources to the health field to facilitate delivery of medical information to practitioners, patients, and the general public; the process by which electronic, visual, and audio communications are used to provide medical care, enhance skills and knowledge, and provide diagnostic and consultative support to providers at distant sites.

Teaching via Telecommunications

Telecommunications can be a valuable tool for clinical proctoring and training of physicians, nurses, and allied health professionals within current standards for higher education, undergraduate and graduate medical education, preceptorships, and continuing medical education.

Needed Updates to Federal Prescribing Policies for Telecommunications

The American Medical Association should advocate to the U.S. Drug Enforcement Administration to end the delay in adopting the necessary federal policies to allow

psychiatrists to prescribe controlled substances, including Schedule II drugs, to patients receiving medical services via telemedicine, in accordance with state laws (Council on Medical Education, p 78, A-95; reaffirmed CME Rep. 1-A-08).

Comment: The committee is aware of severe shortages of child/adolescent psychiatrists in the state. To facilitate greater access to care, the committee believes the American Medical Association should advocate to the U.S. Drug Enforcement Administration to discontinue its longstanding stalling tactics in implementing authorized changes to allow psychiatrists to prescribe controlled substances, including Schedule II drugs, to patients receiving services through telemedicine, in accordance with state laws.

Recommendation 2: Retain as amended.

REPORT OF COUNCIL ON PRACTICE MANAGEMENT SERVICES

CPMS Report 1-A-18

Subject: Reducing Errors in Pharmacy (Resolution 307-A-17)

Presented by: Allen Schultz, MD, Chair, Council on Practice Management Services
Matt Murray, MD, Chair, Ad Hoc Committee on Health Information Technology

Referred to: Reference Committee on Medical Education and Health Care Quality

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Resolution 307, introduced by Lubbock-Crosby-Garza County Medical Society at A-17, asked that the Texas Medical Association study the causes of errors in e-prescribing in pharmacies and suggest ways to reduce those errors.

In researching the stated problem of the resolution, several organizations were contacted to learn how quality issues in pharmacies are addressed, specifically with regard to prescription mishaps that affect patient outcomes.

One such organization is the Alliance for Patient Medication Safety (APMS), which is a federally listed Patient Safety Organization (PSO) that has been operating since 2008. APMS has worked with thousands of independent and small chain pharmacies to improve pharmacy workflow, increase quality of patient care, and reduce risk. APMS has a portal that pharmacy staff can use to report medication safety and quality issues. It gives pharmacies the ability to record medication mishaps as well as adverse events, and have easy access to the Federal Safety Information and Adverse Event Reporting Program (MEDWATCH) and the Vaccine Adverse Event Reporting System (VAERS) forms all in one spot.

The Patient Safety Act allows health care providers to share information transparently and non-punitively for learning purposes without jeopardizing the protection of that data. The act further allows health care providers to study patient safety data, conduct quality assurance and peer review meetings, and perform root cause analysis without fear of exposing that work. Pharmacies within the APMS PSO can learn from aggregate data from over 3,500 regional chain and independent pharmacies.

One recommendation is for TMA to support collection and analysis of e-prescribing mishaps in a transparent and non-punitive manner such as described in the paragraph above.

The Ad Hoc Committee on Health Information Technology (HIT) met with representatives from SureScripts, a network that connects physician to pharmacy to facilitate e-prescribing. Mary Martin, RN, and Jim Green, PharmD, presented to the committee on the SureScripts health information network and its Critical Performance Improvements (CPI) program. Its network reach includes 64 percent of prescribers and 98 percent of retail pharmacies. Its 2017 network quality goal was a 22 percent improvement in prescription accuracy. In order to reach this goal, SureScripts convened hundreds of industry leaders to identify the top e-prescribing “pain points.” Some identified best practices pertained to drug description, Sig, dosage strength, and notes, all of which are detailed in a recently released report of recommended guidelines. The committee suggested that SureScripts publish quality data resulting from its comprehensive review of various e-prescribing metrics. The committee was briefed on the National Council for Prescription Drug Programs (NCPDP), which helps to create and modify national standards for pharmacy, payer, and electronic prescribing processes. Ms. Martin mentioned that TMA may want to consider representation on the NCPDP workgroup. There are three membership categories, including

provider, payer, and vendor. Any interested party can submit a request to develop or change a standard or implementation guide.

The committee recommends TMA's participation in the National Council for Prescription Drug Program (NCPDP) to influence national standards for pharmacies and the e-prescribing process.

The committee also considered specific actions that TMA can take to inform members on best practices to reduce e-prescribing errors when transmitting prescriptions to the pharmacy. The committee collectively agreed that TMA can help by educating physicians on e-prescribing best practices and evaluating areas for process improvement. TMA recently collaborated with ECRI Institute's Partnership for Health IT Safety, which will provide educational opportunities to help members understand and correct potential patient safety issues related to health information technology. TMA can seek resources specific to e-prescribing.

Recommendation 1: That TMA support improving quality and patient outcomes through the collection and analysis of e-prescribing mishaps through reporting in a transparent and non-punitive manner.

Recommendation 2: That TMA participate in the National Council for Prescription Drug Program (NCPDP) to influence national standards for pharmacies and the e-prescribing process.

Recommendation 3: That TMA provide education specific to e-prescribing best practices so that pharmacies receive accurate prescriptions the first time, reducing callbacks to the physician's office.

Related TMA Policy:

265.012 Health Information Technology and Health Information Exchange (abbreviated): 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 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…

(Amended Res. 402-A-05; amended CPMS Rep. 3-A-07; substituted CPMS Rep. 2-A-10; amended CPMS Rep. 2-A-13; amended CPMS Rep. 1-A-14).

REPORT OF COUNCIL ON PRACTICE MANAGEMENT SERVICES

CPMS Report 2-A-18

Subject: HIT Policy Review and New Cyber Security Policy

Presented by: Allen Schultz, MD, Chair, Council on Practice Management Services
Matt Murray, MD, Chair, Ad Hoc Committee on Health Information Technology

Referred to: Reference Committee on Medical Education and Health Care Quality

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The Council on Practice Management Services' Ad Hoc Committee on Health Information Technology (HIT) performed a sunset review of policy 95.029 E-Prescribing, along with other existing TMA policies related to HIT. Based upon this review, the committee found that updates were needed to 95.029, as well as to policy 265.012 Health Information Technology and Health Information Exchange. In amending 265.012, the committee felt it would be appropriate to extract certain sections of the policy on the topics of e-prescribing and HIT, to be categorized as their own, clearly delineated issues and policy statements within the TMA Policy Compendium. In addition, two policies were proposed for deletion. Finally, the committee determined a new policy on cyber security would address a gap in TMA policy. The recommendations of the committee are detailed in this report.

The committee recommends amending TMA policies 95.029 and 265.012 to align with TMA's overall policy goals on the subject of HIT. Amendments to 265.012 include updates for relevance, as well as extraction of certain sections best categorized as their own policy statements; policy 95.029 is amended to include e-prescribing language previously adopted as part of TMA policy 265.012, as follows:

95.029 **Health Information Technology — ~~E-~~Electronic Prescribing:** The Texas Medical Association supports initiatives that increase appropriate utilization of electronic prescribing (e-prescribing). In addition, TMA maintains the following positions related to e-prescribing:

1. TMA supports further development of physician and patient controls of e-prescribing and e-refills including patient health records and patient portals to manage prescriptions.

2. TMA supports positive incentives for the adoption and maintenance of e-prescribing. TMA opposes physician penalties where e-prescribing is not practical, possible, or desired by the patients.

3. TMA supports legislative and regulatory efforts to ensure universal acceptance by pharmacies of electronically transmitted prescriptions.

4. TMA supports development of patient- and condition-specific e-prescribing tools, for example, appropriate rounding of weight-based doses in pediatrics.

5. TMA supports the use of standardized plug-in applications or web-based tools to standardize and simplify e-prescribing.

6. TMA supports cost-free access to patient-specific, medication-related information such as formulary, eligibility, and fill history.

~~Texas law and relevant rules and regulations should be changed to facilitate an electronic means for communicating "brand medically necessary" and to prescribe schedule II controlled substances electronically (Res. 306-A-08).~~

265.012 Health Information Technology ~~and Health Information Exchange~~ Electronic Health Records and Personal Health Records: The Texas Medical Association supports voluntary universal adoption of health information technology (HIT) that supports physician workflow, increases practice efficiency, is safe for patients, and enhances quality of care. TMA believes HIT vendors should adhere to these principles.

Electronic ~~Medical~~ Health Record Adoption

The Texas Medical Association:

1. Supports legislation and other appropriate initiatives that provide positive incentives for physicians to acquire and maintain health information technology.

2. Supports the ability of the physician and patients to change HIT programs or vendors with minimal impact. Systems must have interoperability that allows movement of data between databases without the need for data conversion to ensure compatibility among all HIT systems.

3. Supports appropriate financial, operational, and technical assistance from an inpatient facility and other entities for physicians who need help converting to and maintaining electronic ~~medical~~ health records ~~(EMRs)~~ (EHRs) when it does not unreasonably constrain the physician's choice of which ambulatory ~~HIT~~ EHR system~~s~~ 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~~ EHRs to increase patient safety and decrease errors of omission. These checklists should allow for data entry by any member of the care team under the physician's supervision, and be developed with appropriate quality guidelines as endorsed by nationally recognized medical specialty societies and quality improvement organizations.

6. TMA, where possible, will provide its members with up-to-date, accurate information enabling them to select HIT that improves the quality of their patients' care, interoperates seamlessly with other automated clinical information sources, and enhances the efficiency and viability of their practices.

~~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 4 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 the treatment of the patient.

4. TMA supports legislative efforts directed at providing incentives to facilitate PHR use and maintenance.

5. Physician 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~~ EHRs. There is a degree of precision ~~that~~ with ~~EMRs~~ EHRs that does not exist with the use of paper records. Physicians should not be held liable for innocent

inconsistencies that occur within the ~~EMR~~ EHR environment, for example a computer stamp versus a manual time entry by the physician.

2. TMA supports efforts to hold HIT vendors accountable for developing processes, systems, and customer support that are responsive to patient safety concerns and proactively work to prevent and resolve patient safety concerns.

3. TMA supports the development of a national "no fault" reporting system for errors and near-misses that occur through the use of ~~EMRs~~ EHRs to prevent unintended consequences.

4. TMA supports the development and application of performance standards that are cognizant of the burden of data collection, particularly in the aggregation of multiple quality measures.

5. TMA supports the study and evaluation of the potential impact that physician efforts directed towards compliance with unduly burdensome state and federal regulation may have on patient care. These new compliance burdens compete for the physician's attended and limited resources and may distract the physician from patient care (Amended Res. 402-A-05; amended CPMS Rep. 3-A-07; substituted CPMS Rep. 2-A-10; amended CPMS Rep. 2-A-13; amended CPMS Rep. 1-A-14).

Recommendation 1: Retain as amended.

The committee recommends deletion of the following policies as they are either redundant or no longer relevant:

265.021 **Electronic Medical Records**: The Texas Medical Association opposes compulsory adoption of an electronic medical record if it lacks an appropriate exemption process, and continues to support positive incentives for EMR adoption (Amended Res. 418-A-12).

115.019 **Abolish Compulsory Electronic Health Records**: The Texas Medical Association recommends repeal of compulsory electronic health records and urges our Congressional Delegation to advocate repeal of compulsory electronic health records (Res. 414-A-15).

Recommendation 2: Delete.

The committee recommends addressing health information exchange as a stand-alone policy in the TMA Policy Compendium rather than as a section within existing policy 265.012, as follows:

Health Information Technology — Health Information Exchange: The Texas Medical Association recognizes the following principles concerning electronic health information exchange (HIE):

1. Patient safety, privacy, and quality of care are the guiding principles of all HIE efforts; cost reduction and efficiency are expected byproducts.

2. TMA is a professional organization for physicians and as such recognizes that some parts of patients' medical records should be considered the intellectual property of the physician. HIE efforts should recognize that the physician's work product has value for which he or she, along with the patient, has intrinsic ownership, and therefore both should control its use. Patient records are the documentation of interactions between physicians and patients. Patient privacy protections that

traditionally exist in the patient-physician relationship continue to apply where HIT is used. Physicians must uphold their responsibility to protect and secure all information related to the sacred patient-physician relationship.

3. Patients have the right to withhold information. Physicians may provide a notice to users that the record is incomplete when a patient withholds information.

4. Patient privacy and confidentiality shall be maintained in all HIE efforts by using secure systems and transmission methods.

5. Patients must have complete control over all uses of individually identified medical data. Except for emergencies, or otherwise as required by law, their medical data must not be disclosed or disseminated to third parties without patient consent.

6. Open standards for the interoperable electronic transmission of clinical data should be mutually acceptable to the medical community and compatible with national and regional standards.

Foundational Principles for HIE Participation

7. Participation in HIE, beyond that required by law or in emergencies, should be determined at the local level. Regardless, participants should be able to withdraw upon reasonable notice.

8. HIE should strive to provide, at the point of care as part of the physician's workflow, complete, timely, and relevant patient-focused information in a fully enabled electronic information environment designed to engage patients, transform care delivery, and improve population health. Patients and physicians will have confidence that personal health information is reliable; private; secure; and used with patient consent in appropriate, beneficial ways for patient and public good.

9. Any costs of supporting systems should be borne by all stakeholders, clearly defined, fair, simple to understand, and accountable, and should support the financial viability of the considered practice.

10. To ensure HIE activity remains focused on the patient interest, HIE governance should be representative of and responsive to the needs and concerns of stakeholders, with particular attention to the concerns of physicians and patients.

11. To protect the interest of patients, an HIE provider or entity must define whether and how it will share information for public health research, and surveillance and evaluation of health care quality. When participants choose to allow these uses, patient information must be deidentified unless informed consent has been obtained and can be documented.

12. An HIE provider or entity must be designed and function to enable and enhance coordinated collaboration for improving health and patient safety. Participants should give consideration to special populations who are otherwise incapable of representing themselves (e.g., children; the aged; people who are disabled, uninsured, or homeless).

13. The patient's Social Security number should not be used as the de facto unique patient identifier.

14. Patient data should be transmitted over a secure network, with provisions for authentication and encryption in accordance with HIPAA and other appropriate guidelines. Standard email services do not meet these guidelines. HIE participants need to be aware of potential security risks, including unauthorized physical access and security of computer hardware, and guard against them with technologies such as automatic logout and password protection.

15. HIE operations will not modify original patient data in any way.

16. The HIE entity or provider must have a means to audit, track, and use reasonable efforts to ensure the integrity of all entities or individuals engaged in receiving and converting transaction data.

17. Dissemination of information identifiable with a specific patient is permissible only when the patient provides express permission to do so.

18. The HIE entity or provider should maintain and enforce strict conflict of interest policies that require members to disclose all possible conflicts of interest, to recuse themselves from deliberations on matters in which they have a conflict of interest, and to abstain from voting on such matters. The HIE must further maintain financial transparency in its operations, acknowledging all material sources and uses of funds.

19. State support for HIE is important. However, state government's primary role should be to foster coordination of HIE efforts, including providing access to funding or other financial incentives that promote the adoption of health information technologies. TMA opposes a governmental entity owning or primarily controlling an HIE entity or provider.

20. TMA physicians should cooperate with nongovernmental entities developing HIE solutions with minimal mandates, but only where it leads to physicians' stewardship of the data they produce, and patients' control over data that may identify them.

21. TMA supports national health information standards such as Nationwide Health Information Network, HL7, Continuity of Care Record (CCR)/Continuity of Care Document (CCD), and other standards adopted by the Centers for Medicare & Medicaid Services. In addition to the CCR/CCD contents, HIE participants' data also should include labs, radiology results (text), history and physical, discharge summaries, and progress and other notes.

22. TMA supports HIE participation of the U.S. Department of Veterans Affairs, U.S. Department of Defense, the uninsured, and other populations that may have medical records inadequately integrated into the health care system.

23. TMA supports a legislative safe harbor that limits a physician's liability exposure if patient data provided to an HIE by the physician are breached due to the actions or inactions of the HIE, another HIE participant, or any other person. Each participating individual or entity should be responsible only for their own actions or inactions as these relate to a possible breach of protected health information provided to an HIE.

Data Warehouses — Principles for the Collection, Use, and Warehousing of EHRs and Claims Data

TMA supports policy that any payer, clearinghouse, vendor, or other entity that collects, warehouses, and uses EHRs and claims data adhere to the following principles. For purposes of this policy, the compilation of electronic records in a physician's office does not constitute a data warehouse.

1. EHRs and claims data transmitted for any purpose to a third party must contain the minimum necessary needed to accomplish the intended purpose. TMA supports the development of simple and efficient tools to facilitate extraction and submission of such data sets.

2. The physician and his or her patients must be informed of and provide permission for third-party analyses undertaken with the physician's EHR and claims data, including the data being studied and how the results will be used.

3. The physician must be compensated by the requesting entity for any additional work required to collect data.

4. Criteria developed for the analysis of physician claims or medical record data must be open for review and input.

5. Methods and criteria for analyzing the EHR and claims data must be provided to the physician or an independent third party so that reanalysis of the data can be performed.

6. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his or her EHR and claims data.

7. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care processes.

8. The warehouse vendor must take the necessary steps to ensure the confidentiality and integrity of patient records and claims data.

9. Organizations that store, transmit, or use patient records or claims data must have internal policies and procedures in place that adequately protect the integrity, security, and confidentiality of such data.

10. EHR data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.

11. Following the request from a physician to transfer his or her data to another data warehouse, the current warehouse vendor must transfer the EHR and claims data and must delete or destroy the data from its data warehouse once the transfer has been completed and confirmed, at the request of the physician or patient.

Recommendation 3: Adoption of TMA's previously passed policy stance on health information exchange now categorized separately and titled as Health Information Technology — Health Information Exchange.

Finally, to address a gap in TMA policy on cyber security as it relates to HIT, the committee proposes the following addition to the TMA Policy Compendium:

Health Information Technology — Cyber Security: Recognizing that cyber crimes, such as use of ransomware and malware, are a threat to patient care and to physician practice operations, the Texas Medical Association supports education, policies, and tools that help physicians protect patient health information and electronic resources. Further, TMA supports HIPAA privacy and security education, policies, and tools that help physicians maintain HIPAA policies and procedures, including cyber security precautions, to reduce the risk of attacks and other unauthorized access against a computer system and the information it contains.

Recommendation 4: Adoption of new policy Health Information Technology — Cyber Security.

Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 201
A-18

Subject: Incorporating High-Value Care Into Undergraduate and Graduate Medical Education in Texas

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

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Whereas, An estimated 20 percent, or $765 billion, of health care expenditures may be spent on unnecessary tests and medical procedures; and

Whereas, Overuse of noninvasive radiologic imaging alone accounts for an estimated 0.96 percent to 1.75 percent (between $18 billion and $33 billion) of total U.S. health care spending; and

Whereas, Seventy-three percent of physicians say the frequency of unnecessary tests and procedures is a very or somewhat serious problem; and

Whereas, Fifty-eight percent of physicians report that physicians themselves are in the best position to address the problem; and

Whereas, Through increased research, physicians and physician scientists increasingly recognize this issue as important and relevant, with a near-doubling of articles on overuse in medical care from 2014 to 2015; and

Whereas, The training environments medical students and residents are exposed to have long-lasting effects on their practice behaviors; and

Whereas, It has been shown that residents trained in areas with lower health care spending have lower spending patterns as practicing physicians; and

Whereas, The ABIM Foundation, along with nine physician medical societies, created a list of common diagnostic tests or treatments with no evidence of meaningful benefit, in an effort to control unnecessary spending; and

Whereas, The U.S. Students and Trainees Advocating for Resource Stewardship (STARS) program, a *Choosing Wisely* program for medical education, was established in 2017 with 25 medical schools nationwide participating in the first year, four of which were Texas medical schools; and

Whereas, Medical schools such as The University of Texas at Austin Dell Medical School already have created an assistant-dean-level office for health care value education, in addition to resources such as interactive learning modules any student can access for free to learn the foundational concepts of health care value delivery; and

Whereas, The Texas Medical Association, as well as 70 other medical societies, already advocate for the use of the *Choosing Wisely* recommendations among physicians; therefore be it

RESOLVED, That the Texas Medical Association support the inclusion and integration of topics of health care value in medical education; and be it further

RESOLVED, That the Texas Medical Association work with the appropriate parties to make the *Choosing Wisely* U.S. Students and Trainees Advocating for Resource Stewardship (STARS) curriculum or a similar curriculum more widely available to TMA members.

Related TMA Policy:
265.023 Choosing Wisely® Campaign: The Texas Medical Association advocates the adoption of the Choosing Wisely campaign (CHCQ Rep. 1-A-13).

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).

200.020 Medical Education Curriculum: Medical schools should incorporate in their curricula a broad range of educational opportunities and perspectives, not exclusively related to the basic sciences (Council on Medical Education, p 90, A-94; amended CME Rep. 4-A-04; amended CME Rep. 2-A-14).

Related AMA Policy:
Support for the Concepts of the Choosing Wisely Program D-155.988
Our AMA supports the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program.

11.1.2 Physician Stewardship of Health Care Resources
Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians also have a long-recognized obligation to patients in general to promote public health and access to care. This obligation requires physicians to be prudent stewards of the shared societal resources with which they are entrusted. Managing health care resources responsibly for the benefit of all patients is compatible with physicians' primary obligation to serve the interests of individual patients.

To fulfill their obligation to be prudent stewards of health care resources, physicians should:

(a) Base recommendations and decisions on patients' medical needs.

(b) Use scientifically grounded evidence to inform professional decisions when available.

(c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals.

(d) Endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals.

(e) Choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources.

(f) Be transparent about alternatives, including disclosing when resource constraints play a role in decision making.

(g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile, which may include consulting other physicians, an ethics committee, or other appropriate resource.

Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:

(h) Encouraging health care administrators and organizations to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship.

(i) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect overall health care spending.

(j) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.

AMA Principles of Medical Ethics: I,V,VII,VIII,IX

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

Value-Based Decision-Making in the Health Care System H-450.938
PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING

1. Physicians should encourage their patients to participate in making value-based health care decisions.

2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.

3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.

4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.

5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.

6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life.

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 202
A-18

Subject: Addressing Gender Bias in Undergraduate Medical Education With Implicit Bias Training

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

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Whereas, The number of women in residency increased by 3.4 percent from 2005 to 2015 with nearly half (45.8 percent) of all residents being women in 2015; and

Whereas, Nearly all specialties showed an increased percentage of female residents from 2005 to 2015; and

Whereas, Residencies still do not display nearly equal representation of both genders; and

Whereas, Only 14.8 percent of orthopedic surgery residents, 17.3 percent of neurosurgery residents, and 22 percent of thoracic surgery residents were women in 2015; and

Whereas, In contrast, 82.8 percent of obstetrics and gynecology residents and 71.1 percent of pediatric residents were women in 2015; and

Whereas, Additionally, 34 percent of emergency medicine residents were women in 2017, and 70 percent of female residents perceived gender bias in the academic environment compared with only 22 percent of male residents; and

Whereas, Residents are not the only ones experiencing bias; 92.8 percent of female and 83.2 percent of male medical students reported encountering (i.e., experiencing, observing, hearing about) gender discrimination and sexual harassment in some medical training context; and

Whereas, Almost 35 percent of medical students reported that encountering gender discrimination or sexual harassment influenced their medical specialty choice and/or residency program ranking; and

Whereas, Implicit bias training has been shown to improve attitudes towards women in science, technology, engineering, math, and the medical fields; and

Whereas, Compared with male students, female medical students more commonly report a lack of available mentors; and

Whereas, Between 90 percent and 96 percent of medical students view mentorship in medical school as beneficial; therefore be it

RESOLVED, That the Texas Medical Association support the implementation of implicit bias training for all Texas medical school faculty; and be it further

RESOLVED, That the Texas Medical Association advocate for the creation and implementation of formal mentorship programs at medical schools between residents, fellows, or attending physicians and female medical students for specialties in which women are underrepresented.

Related TMA Policy:
245.010 Physician Discrimination Against International Medical Graduates: The Texas Medical Association supports and promotes the right of every licensed physician to be treated meritoriously without discrimination based on national origin or geographic location of medical school (Amended Res. 301-I-99; amended BOC Rep. 6-A-09).

245.005 Age Discrimination: The Texas Medical Association believes the same standard of proof of mental and physical competence to practice medicine and obtain professional liability insurance should be uniform for all physicians without discrimination as to age (Res. 28H, p 185, I-93; reaffirmed BOC Rep. 3-A-03; reaffirmed BOC Rep. 6-A-13).

Related AMA Policy:
9.5.5 Gender Discrimination in Medicine: Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians. Collectively, physicians should actively advocate for and develop family-friendly policies that:
(a) Promote fairness in the workplace, including providing for:
(i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family;
(ii) on-site child care services for dependent children;
(iii) job security for physicians who are temporarily not in practice due to pregnancy or family obligations.
(b) Promote fairness in academic medical settings by:
(i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure;
(ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research;
(iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks;
(iv) structuring the mentoring process through a fair and visible system.
(c) Take steps to mitigate gender bias in research and publication.
AMA Principles of Medical Ethics: II,VII
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Women in Medicine H-525.992
Our AMA reaffirms its policy of commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine.

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Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 203
A-18

Subject: Freedom From Maintenance of Certification

Introduced by: Ori Z. Hampel, MD

Referred to: Reference Committee on Medical Education and Health Care Quality

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Whereas, Senate Bill 1148 (2017) concerning maintenance of certification (MOC) was introduced and sponsored in the Texas Legislature by Sen. Dawn Buckingham, MD (R-Lakeway), and Rep. Greg Bonnen, MD (R-Friendswood), for the benefit of Texas patients and physicians; and

Whereas, SB 1148 took effect on Jan. 1, 2018; and

Whereas, The MOC mandate by the member boards of the American Board of Medical Specialties (ABMS) has been very costly to Texas physicians in both time and money; and

Whereas, The ABMS MOC process has never been shown to improve quality of care and has never been shown to improve a physician's clinical skills; and

Whereas, Texas law states that health-related facilities, institutions, and programs, unless exempted, may differentiate between physicians based on a physician's MOC if the voting physician members of the entity's organized medical staff vote to authorize the differentiation. Furthermore, this authorization can be made only by the voting physician members of the entity's organized medical staff and not by the entity's governing body, administration, or any other person. Any such authorization made prior to the existence of SB 1148 was given prior to physicians having the legal protection of a choice in this matter; and

Whereas, There have been documented instances in which health-related entities have denied, prevented, ignored, and/or negated such a vote by the medical staff; therefore be it

RESOLVED, That the Texas Medical Association take the position in its advocacy efforts that all requirements for maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) should be considered null and void effective Jan. 1, 2018; and be it further

RESOLVED, That TMA take the position in its advocacy efforts that any requirements for maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) require the vote of the medical staff (or satisfaction of another exception under the law); and be it further

RESOLVED, That TMA take the position in its advocacy efforts that any vote for requiring maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition under Senate Bill 1148 taken before the effective date of the bill should be considered null and void effective Jan. 1, 2018.

Related TMA Policy:
175.018 Maintenance of Certification: The maintenance of certification (MOC) process should become substantially more physician friendly, offered at a reasonable cost to physicians and requiring no more than one missed day of patient care per recertification cycle. Time spent preparing for MOC should count as AMA PRA Category 1 CreditTM. Use of ongoing educational processes, such as annual board certification, should be an option for practitioners in all specialties. There should be greater coordination between American Board of Medical Specialties' boards to ensure that the demands of MOC processes are similar across all specialties (Amended Res. 305-A-07; amended CME Rep. 6-A-17).

175.021 Maintenance of Certification Requirement: The Texas Medical Association supports the American Medical Association's Principles of Maintenance of Certification (MOC) H-275.924 to ensure physician's choice of lifelong learning, and will pursue legislation that eliminates discrimination by the State of Texas, employers, hospitals, and payers based on the American Board of Medical Specialties' proprietary MOC program as a requirement for licensure, employment, hospital staff membership, and payments for medical care in Texas (Res. 206-A-16).

175.023 Initial Guiding Principles on Maintenance of Certification: The Texas Medical Association believes in the following guiding principles regarding maintenance of certification:

1. Good medical practice necessitates a commitment by each physician to life-long learning.
2. Physicians have a social contract to maintain professional competency throughout their professional careers.
3. Action is needed to maintain the privilege of self-governance and decrease the potential for governmental interference.
4. Maintenance of certification (MOC) should be a meaningful process deeply rooted in best practices, responsive to participating physicians, and highly valued by physicians and the public.

<u>Impact of MOC</u>
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).

<u>MOC Operational Characteristics</u>
8. The MOC process should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
9. The MOC process should use multiple options to recognize and accommodate different learning styles for physicians.
10. The MOC process should be designed with sufficient flexibility to accommodate the broad variety of physician practice characteristics, including nonclinical activities such as teaching, leadership roles, administrative, and research.
11. Physicians with lifetime board certification should not be required to seek recertification but should be afforded the opportunity for voluntary recertification.
12. High-stakes exams, including closed-book exams, should not be mandated as part of the MOC process.
13. Charges to physicians in relation to the MOC process should not be cost prohibitive but should be reasonable, not resulting in a barrier to practice.

14. Changes to the MOC process should undergo a vigorous evaluation to ensure the requirements are relevant, feasible, reasonably affordable, and accessible.
15. Individual boards should develop MOC requirements in conjunction with evaluation and feedback from its diplomates.
16. ABMS boards should make a diligent effort to inform diplomates about changes in MOC requirements, including the rationale or evidence behind the changes, and allow sufficient time for diplomates to make any changes necessary to comply with those requirements.
17. MOC requirements should be updated to reflect ongoing changes in health care delivery systems and medical practice, including the establishment of new fields of medicine.
18. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake, intent to maintain or change practice, and assess the impact on individual practices and the specialty as a whole.
19. Diplomates should have flexibility in selecting sources of MOC-related continuing medical education (CME) programming and should not be mandated or limited to participation in CME provided by American Board of Medical Specialties member boards.
20. Physicians should be exempted from MOC for no less than five years after attainment of initial board certification.
21. Patient satisfaction programs such as the Consumer Assessment of Healthcare Providers and Systems patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties and should not be part of the MOC process.
22. The MOC program should be a tool for process improvement and should not be constructed as a punitive measure to the detriment of physicians' practices. Careful consideration should be given to the use of physician-specific data to be publicly released regarding MOC participation.
23. The MOC program should use commonly accepted practices for identifying core competencies applicable across specialties but also should provide the flexibility necessary to reasonably reflect the distinct characteristics of each specialty.
24. The MOC process should be streamlined to prevent overburdening physicians with more than one board certification by removing duplicative requirements. MOC requirements for diplomates with added qualifications should be applicable to the diplomate's primary area of practice (CME Rep. 6-A-17).

175.024 Monitoring Maintenance of Certification Reforms: The Texas Medical Association will: (1) monitor the American Board of Medical Specialties (ABMS') Program for Maintenance of Certification (MOC), American Osteopathic Association's Osteopathic Continuous Certification Program, and other MOC providers in direct correlation to adopted TMA Initial Guiding Principles on MOC; (2) continue to monitor the American Medical Association's efforts as the national liaison with ABMS and other MOC providers, with particular focus on AMA's work to address physician concerns and calls for MOC reform; (3) inform AMA and ABMS of adopted TMA Initial Guiding Principles on MOC; and (4) continue to assess physician views and experiences with MOC and Osteopathic Continuous Certification through activities by the Council on Medical Education as these programs incorporate reforms and communicate these findings to AMA, ABMS, and other appropriate MOC providers (CME Rep. 6-A-17).

Related AMA Policy:
Maintenance of Certification H-275.924
AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.

2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.

3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).

5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.

7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.

8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.

9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 CreditTM, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."

10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.

15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care.

20. Any assessment should be used to guide physicians' self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards' websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards' websites or physician certification databases even if the diplomate chooses not to participate in MOC.

27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.

Maintenance of Certification and Osteopathic Continuous Certification D-275.954
Our AMA will:

1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.

3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.

4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.

5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.

6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.

7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.

8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.

9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.

10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.

11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.

12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.

13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.

14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.

15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.

16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.

17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.

18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.

19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.

20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.

21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.

22. Continue to participate in the National Alliance for Physician Competence forums.

23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.

24. Continue to assist physicians in practice performance improvement.

25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.

26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.

27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.

28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.

29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.

32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

34. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.

35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for MOC Part IV.

Supplement
Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 204
A-18

Subject: Creating a Nonprofit Texas Board of Medical Specialties

Introduced by: Smith County Medical Society

Referred to: Reference Committee on Medical Education and Health Care Quality

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Whereas, The maintenance of board certification for Texas physicians through the American Board of Medical Specialties has proven time-consuming, expensive, and of no demonstrated value to the delivery of quality care; and

Whereas, Excess time and costs have driven many physicians to give up their board certification; and

Whereas, Many physicians do not see the value in the certification, and most patients do not see it as a true quality indicator; and

Whereas, Most of the hurdles to maintain certification have little to do with our actual medical practices; and

Whereas, Most physicians are licensed only to practice in Texas; thus there is no need to have a national organization located outside of Texas to determine who qualifies as a "board certified" practitioner; and

Whereas, Other Texas-based professions have Texas-based organizations to certify the accomplishment of specialization (e.g., the Texas Board of Legal Specialization is the only governing board authorized to certify attorneys in legal specialty areas in Texas); and

Whereas, The goal of the Texas Board of Medical Specialties would be to certify the clinical skill and knowledge development of Texas physician specialists with a focus on developing lifetime learning of the clinical information that will improve patient care; and

Whereas, It is time for Texas physicians to take back the criteria for certifying the quality of Texas physicians; therefore be it

RESOLVED, That the Texas Medical Association cause to be created a TMA-endorsed 501(c)(3) nonprofit Texas Board of Medical Specialties to serve the purpose of certifying physicians practicing in Texas.

Fiscal Note: Start-up costs of $500,000 to $1 million

Related TMA Policy:
175.018 Maintenance of Certification: The maintenance of certification (MOC) process should become substantially more physician friendly, offered at a reasonable cost to physicians and requiring no more than one missed day of patient care per recertification cycle. Time spent preparing for MOC should count as AMA PRA Category 1 Credit™. Use of ongoing educational processes, such as annual board certification, should be an option for practitioners in all specialties. There should be greater coordination

between American Board of Medical Specialties' boards to ensure that the demands of MOC processes are similar across all specialties (Amended Res. 305-A-07; amended CME Rep. 6-A-17).

175.021 Maintenance of Certification Requirement: The Texas Medical Association supports the American Medical Association's Principles of Maintenance of Certification (MOC) H-275.924 to ensure physician's choice of lifelong learning, and will pursue legislation that eliminates discrimination by the State of Texas, employers, hospitals, and payers based on the American Board of Medical Specialties' proprietary MOC program as a requirement for licensure, employment, hospital staff membership, and payments for medical care in Texas (Res. 206-A-16).

175.023 Initial Guiding Principles on Maintenance of Certification: The Texas Medical Association believes in the following guiding principles regarding maintenance of certification:

1. Good medical practice necessitates a commitment by each physician to life-long learning.
2. Physicians have a social contract to maintain professional competency throughout their professional careers.
3. Action is needed to maintain the privilege of self-governance and decrease the potential for governmental interference.
4. Maintenance of certification (MOC) should be a meaningful process deeply rooted in best practices, responsive to participating physicians, and highly valued by physicians and the public.

<u>Impact of MOC</u>

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).

<u>MOC Operational Characteristics</u>

8. The MOC process should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
9. The MOC process should use multiple options to recognize and accommodate different learning styles for physicians.
10. The MOC process should be designed with sufficient flexibility to accommodate the broad variety of physician practice characteristics, including nonclinical activities such as teaching, leadership roles, administrative, and research.
11. Physicians with lifetime board certification should not be required to seek recertification but should be afforded the opportunity for voluntary recertification.
12. High-stakes exams, including closed-book exams, should not be mandated as part of the MOC process.
13. Charges to physicians in relation to the MOC process should not be cost prohibitive but should be reasonable, not resulting in a barrier to practice.
14. Changes to the MOC process should undergo a vigorous evaluation to ensure the requirements are relevant, feasible, reasonably affordable, and accessible.
15. Individual boards should develop MOC requirements in conjunction with evaluation and feedback from its diplomates.

16. ABMS boards should make a diligent effort to inform diplomates about changes in MOC requirements, including the rationale or evidence behind the changes, and allow sufficient time for diplomates to make any changes necessary to comply with those requirements.
17. MOC requirements should be updated to reflect ongoing changes in health care delivery systems and medical practice, including the establishment of new fields of medicine.
18. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake, intent to maintain or change practice, and assess the impact on individual practices and the specialty as a whole.
19. Diplomates should have flexibility in selecting sources of MOC-related continuing medical education (CME) programming and should not be mandated or limited to participation in CME provided by American Board of Medical Specialties member boards.
20. Physicians should be exempted from MOC for no less than five years after attainment of initial board certification.
21. Patient satisfaction programs such as the Consumer Assessment of Healthcare Providers and Systems patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties and should not be part of the MOC process.
22. The MOC program should be a tool for process improvement and should not be constructed as a punitive measure to the detriment of physicians' practices. Careful consideration should be given to the use of physician-specific data to be publicly released regarding MOC participation.
23. The MOC program should use commonly accepted practices for identifying core competencies applicable across specialties but also should provide the flexibility necessary to reasonably reflect the distinct characteristics of each specialty.
24. The MOC process should be streamlined to prevent overburdening physicians with more than one board certification by removing duplicative requirements. MOC requirements for diplomates with added qualifications should be applicable to the diplomate's primary area of practice (CME Rep. 6-A-17).

175.024 Monitoring Maintenance of Certification Reforms: The Texas Medical Association will: (1) monitor the American Board of Medical Specialties (ABMS') Program for Maintenance of Certification (MOC), American Osteopathic Association's Osteopathic Continuous Certification Program, and other MOC providers in direct correlation to adopted TMA Initial Guiding Principles on MOC; (2) continue to monitor the American Medical Association's efforts as the national liaison with ABMS and other MOC providers, with particular focus on AMA's work to address physician concerns and calls for MOC reform; (3) inform AMA and ABMS of adopted TMA Initial Guiding Principles on MOC; and (4) continue to assess physician views and experiences with MOC and Osteopathic Continuous Certification through activities by the Council on Medical Education as these programs incorporate reforms and communicate these findings to AMA, ABMS, and other appropriate MOC providers (CME Rep. 6-A-17).

Related AMA Policy:
Maintenance of Certification H-275.924

AMA Principles on Maintenance of Certification (MOC)
1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.

2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.

3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.

4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).

5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.

7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.

8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.

9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 CreditTM, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."

10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.

15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care.

20. Any assessment should be used to guide physicians' self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards' websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards' websites or physician certification databases even if the diplomate chooses not to participate in MOC.

27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.

Maintenance of Certification and Osteopathic Continuous Certification D-275.954
Our AMA will:

1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.

3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.

4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and MOC.

5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of MOC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.

6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.

7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.

8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from MOC requirements.

9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting MOC and certifying examinations.

10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.

11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, particularly to ensure that MOC is specifically relevant to the physician's current practice.

12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for MOC; (b) support ABMS member board activities in facilitating the use of MOC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet MOC requirements.

13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.

14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.

15. Encourage the ABMS to use data from MOC to track whether physicians are maintaining certification and share this data with the AMA.

16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and MOC Committees.

17. Continue to monitor the actions of professional societies regarding recommendations for modification of MOC.

18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant MOC process for its members.

19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC requirements for their specific board and the timelines for accomplishing those requirements.

20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.

21. Recommend to the ABMS that all physician members of those boards governing the MOC process be required to participate in MOC.

22. Continue to participate in the National Alliance for Physician Competence forums.

23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC.

24. Continue to assist physicians in practice performance improvement.

25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.

26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.

27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.

28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.

29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.

32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

34. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.

35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for MOC Part IV.

Supplement
Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 205
A-18

Subject: Graduate Associate Physicians

Introduced by: International Medical Graduates Section

Referred to: Reference Committee on Medical Education and Health Care Quality

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Whereas, The Association of American Medical Colleges projects the country's growing physician shortage may be as high as 121,000 by the year 2030; and

Whereas, U.S. medical school graduates and international medical graduates (IMGs) who are eligible to apply for graduate medical education in the United States have completed four years of medical education, and IMGs also hold degrees from their respective medical schools. In addition, IMGs must undergo a credentialing process by the Educational Commission for Foreign Medical Graduates (ECFMG) that includes a review of their educational background; passage of the same exams as U.S. graduates: United States Medical Licensing Exam Steps I and II-Clinical Knowledge and Clinical Skills; and passage of an English language proficiency exam; and

Whereas, IMGs typically bring with them a wealth of training, clinical, research, and teaching experience; and

Whereas, Many U.S. medical school graduates and ECFMG-certified IMGs are unable to obtain a residency position each year because of the limited number of available slots; and

Whereas, In 2018 at the national level, 30,232 first-year residency positions were available for 43,909 total applicants to the National Resident Matching Program (NRMP) Main Match; and

Whereas, In recent years, thousands of physicians have been unable to match to residency positions. In the 2018 NRMP, only 1,171 positions were offered in the post-match process in comparison with 8,063 applicants who did not match during the main match, including 1,078 U.S. medical school seniors and 5,280 IMGs (note that this excludes the American Osteopathic Association DO Match statistics); and

Whereas, The more years that pass during which a physician is unable to be matched, the more diminished the chances are that a match will occur at all, meaning four years of medical school for U.S. graduates and perhaps additional years of training for IMGs may be forfeited; and

Whereas, A large number of U.S. medical graduates and IMGs with specific U.S. legal status may be available to provide medical care with appropriate supervision; and

Whereas, TMA has a policy that has lost its relevance in light of advanced practice registered nurses providing patient care with as little as 700 hours of training in comparison with medical graduates with an estimated 15,000 hours of medical education who are not able to provide medical care; and

Whereas, Reevaluation is needed concerning TMA's 2015 policy statement 30.036 New Licensing Category for Assistant Physicians from the Committee on Physician Distribution and Health Care Access, which reads that TMA opposes the creation of special licensing pathways for physicians who have not

completed a year of residency training, recognizing primary care as encompassing specialties that require the completion of a full residency training process in the relevant specialties, and opposes lower standards of licensing for physicians and other health professions in medically underserved areas; and

Whereas, A state licensing category of graduate associate physician should be established in Texas to allow U.S. medical school graduates and ECFMG-certified international medical graduates with specific U.S. legal status to provide medical care under the supervision of licensed physicians. Supervising physicians should be practicing in a specialty for which there is an inadequate supply in the state, be in good standing, and have a minimum of five years of post-residency patient care experience; and

Whereas, The professional experience gained while working as graduate associate physicians may be beneficial to these physicians in future applications for residency positions; therefore be it

RESOLVED, That the Texas Medical Association delete TMA Policy 30.036 New Licensing Category for Assistant Physicians; and be it further

RESOLVED, That the Texas Medical Association draft a legislative bill and advocate for its passage during the 2019 Texas legislative session to establish a licensing program for qualified U.S. medical school graduates and ECFMG-certified international medical graduates with specific U.S. legal status who have not entered residency training due to a shortage of residency positions. The licensee would be limited to medical care provided under the supervision of a physician in a specialty for which there is a physician shortage, be in good standing, and have a minimum of five years of post-residency patient care experience.

Related TMA Policy:
30.036 New Licensing Category for Assistant Physicians: The Texas Medical Association opposes the creation of special licensing pathways for physicians who have not completed a year of residency training. Further, TMA recognizes primary care as encompassing specialties that require the completion of a full residency training process in the relevant specialties. TMA opposes lower standards of licensing for physicians and other health professions in medically underserved areas (CM-PDHCA Rep. 2-A-15).

Related AMA Policy:
Practicing Medicine by Non-Physicians H-160.949
Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;

(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;

(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and

(6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

Sources:

1. Physician Supply and Demand Through 2030: Key Findings, Association of American Medical Colleges, 2018.
2. National Resident Matching Program Advance Data Tables 2018 Main Residency Match®, Washington, DC, www.nrmp.org.

Revised for Supplement
Items in Supplement are in italics.

AGENDA
REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH
Friday, May 18, 2018
JW Marriott San Antonio Hill Country Resort, Level 2, Cibolo Ballroom 5

1. Council on Science and Public Health Report 2 –Addressing the Diaper Gap (Resolution 305-A-17)

2. Council on Science and Public Health Report 3 – Vitamin D3 Supplementation (Resolution 320-A-17)

3. Council on Science and Public Health Report 4 – Implementing a Sugar-Sweetened Beverage Tax in Texas (Resolution 312-A-17)

4. Council on Science and Public Health Report 5 – Policy Review

5. Council on Science and Public Health Report 6 – Physician Role in Increasing Vaccination for HPV

6. Council on Science and Public Health Report 7 – Evidence-Based Management of Substance Use Disorders

7. Council on Science and Public Health Report 8 – Improving Electronic Health Records, Health Information Exchange and other Health Information Technology Products to Address Issues of Sex and Gender

8. Committee on Cancer Report 1 – Policy Review

9. Committee on Child and Adolescent Health Report 1 – Policy Review

10. Committee on Child and Adolescent Health Report 2 – Referred 2017 Resolutions Relating to Concussions and Head Injuries

11. Committee on Infectious Diseases Report 1 – Policy Review

12. Committee on Reproductive, Women's, and Perinatal Health Report 1 – Evaluation and Management of Stillbirth

13. Resolution 301 – Synthetic Cannabis Educational Resources for Providers (Medical Student Section)

14. Resolution 302 – Appropriate Physician Oversight of EMS Medical Practices (Travis County Medical Society)

15. Resolution 303 – "Bathroom" Bills (Harris County Medical Society)

16. Resolution 304 – Improving the LGBTQI+ Patient Health Care Experience (Medical Student Section)

17. Resolution 305 – Addressing Food Deserts in Texas (Medical Student Section)

18. Resolution 306 – Addressing HB 3859 – A Misstep in the Protection of Foster Care Children (Medical Student Section)

19. Resolution 307 – Restriction of Provisions of HB 2561 to Schedule II Drugs (Bexar County Medical Society)

20. Resolution 308 – Texas Prescription Drug Monitoring Program Data Integration into Electronic Health Record Technology (Medical Student Section)

21. Resolution 309 – Implementing Blood Glucose Screening in Texas Schools (Medical Student Section)

22. Resolution 310 – Community Health Workers and HPV Vaccination (Medical Student Section)

23. Resolution 311 – Encouraging Unstructured Playtime in School (Medical Student Section)

24. Resolution 312 – Identification Bracelets for Patients with Hearing Loss (Tarrant County Medical Society)

25. *Resolution 313 – Raising the Minimum Purchase Age for All Guns to 21 (Ryan Van Ramshorst, MD, Texas Pediatric Society)*

26. *Resolution 314 – Extreme Risk Protection Order and Gun Violence (Ryan Van Ramshorst, MD, Texas Pediatric Society)*

REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSPH Report 2-A-18

Subject: Addressing the Diaper Gap (Resolution 305-A-17)

Presented by: David Lakey, MD, Chair

Referred to: Reference Committee on Science and Public Health

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Resolution 305 from the Medical Student Section (MSS) was considered at the 2017 House of Delegates. The resolution called on the Texas Medical Association to advocate for the elimination or a reduction of the taxes imposed on infant and adult diapers and for TMA to forward the resolution to the AMA's House of Delegates. TMA's House of Delegates heard testimony from the MSS on the hardship for many Texans for whom diapers are a financial burden. Others expressed concern about TMA taking action on state tax matters and commented that diapers are not the only items of necessity that present a burden to many Texans. The resolution was referred to TMA's Council on Science and Public Health, Council on Legislation, and Office of the General Counsel for further study.

Diaper Need Among Children and Adults

Diaper need is described as having an insufficient supply of diapers to protect the health of the infant or toddler because of insufficient family income for these costly purchases. There is little study on diaper need, but the National Diaper Bank Network (NDBN) estimates there are 11 million children under age 3 in the United States, and almost half are in need of diapers. About 10 percent of U.S. children under age 3 reside in Texas, and NDBN estimates half of these 1.1 million children are in need of diapers. NDBN's estimates are based on the poverty level of children in Texas — with 25 percent living in a household at or below 200 percent of the federal poverty level ($49,200/year for a family of four) and 25 percent living at or below 100 percent of the federal poverty level ($24,600/year for a family of four).

Some U.S. residents at lower socioeconomic levels may receive public benefits to cover some of the essential needs of daily living, but this generally does not include cash assistance. The large national support programs for babies and toddlers include the Women, Infants, and Children (WIC) program and the Supplemental Nutrition Assistance Program (SNAP) (families and the elderly also can qualify for SNAP). These programs provide resources for families to purchase foods, as well as nutrition education.

Some adults may be eligible for cash assistance through the federal and state Temporary Assistance for Needy Families program if they are unemployed (but must meet certain work-related requirements) and have at least one child under the age of 18 ; however, to be eligible, their financial resources must be very limited. In Texas, the maximum monthly benefit for a family with one parent and one child under age 18 would be $78; for two children, the monthly benefit would be $163. While the family may have other benefits such as Medicaid, SNAP, and/or WIC to support other household needs, the cost of diapers could represent a significant proportion of a family's cash resources.

A frequently used estimate from the New Kids Center on the cost of diapers for infants is $936 per year, or about 14 percent of the income of families in the lowest quintile of income. However, a cursory review of possible costs for diapers in Texas indicated a higher cost of diapers over the first year of life and continuing up to age 3 years.

Diaper need among adults also is a concern. The Centers for Disease Control and Prevention (CDC) defines adult incontinence as the involuntary loss of bladder or bowel control (loss of control can be

described using different measurements such as frequency, amount, or type). From a survey of people over age 65 living in different types of residences (2007-10), CDC reports that up to half of older Americans have either short- or long-term incontinence. Incontinence was more common among those living in residential facilities including long-term care facilities; but still, the high rates indicate a substantial financial cost to the facilities and to individuals — up to $19.5 billion in 2000 alone. Yet, most of the estimated cost ($14.2 billion) went towards "routine care" (e.g., diapers, pads) of those living in the community, as they were most likely to be bearing these costs directly.

Similarly, a 2014 review of studies related to urgency urinary incontinence in the United States described the extensive costs of incontinence, which included the costs of direct medical care, indirect medical care, and other indirect costs. The indirect medical care costs for adults not in an institution were for routine care including pads, diapers, laundry, and the like, representing up to 70 percent of the total costs of incontinence — costs that fall on individuals and their family.

An estimate of the number or proportion of Texans who may be in need of diapers or other related costs and living in a home setting could not be readily obtained. However, lower income people of any age with a disability are potentially enrolled in the federal Supplemental Security Income (SSI) program, which provides benefits to 657,800 Texans (2016). SSI is a cash assistance program for people who have a severe disability and those aged 65 or older with a disability and with very limited financial resources. SSI also adds Medicaid coverage for the recipient. In 2016, the largest group of Texas SSI recipients were those aged 18-64, totaling 342,024 (minors = 137,546; 65+ = 178,329). There is a maximum monthly cash payment of $484 under SSI. As in other states, those with SSI/Medicaid living in a long-term care setting and in need of diapers or pads would have these products covered under Medicaid, but an individual who has incontinence, is on SSI, and lives at home would have limited income resources and would potentially have a diaper need.

Problems With Not Having Diapers

A 2010 study of low-income pregnant and parenting mothers (including grandparents) was one of the first to assess the issues and concerns of mothers and pregnant women. The study included questions on access to diapers for their infants. About 30 percent reported diaper need — meaning they lacked an adequate supply of diapers and had to seek assistance from others or they stretched their use of the diapers they had. Women who had diaper needs also reported mental health problems. The authors concluded that diaper or other material needs could be associated with mental health concerns that contribute to stress or depression. Addressing diaper need may be one way to minimize this gap in lower income families.

Social and environmental factors have a significant influence on health outcomes. The American Medical Association and the American Academy of Pediatrics recommend screening for risk factors within social determinants of health by asking family members questions about basic material needs.

Sales Tax Exemptions in the United States and Texas

Most states apply a sales tax to tangible personal property (TPP) items that are purchased for personal use. TPP is property that can be touched or moved such as equipment, furniture, and other possessions. Texas provides sales tax exemptions for many TPP items if they are identified as personal necessities such as most groceries, medical purchases, prosthetics, some over-the-counter drugs, and supplies for agriculture. Sales tax exemptions also can be provided if the items generate income for the individual or in some cases because of difficulty in collecting the tax.

While concerns about a diaper gap have been raised for several years, a national focus was raised on a sales tax exemption at a 2016 White House meeting on the "Diaper Divide," which proposed funding initiatives to address the diaper gap. Federal legislation was filed (HR 4055 by K. Ellison and R. DeLauro and companion bill S 3070 by A. Franken and B. Casey, the Hygiene Assistance for Families of Infants

and Toddlers Act) that would have allowed for grants to states to develop innovative programming to improve access to diapers. The legislation was not approved.

Since 2014, a number of states have considered legislation to remove the sales tax on diapers and/or feminine hygiene products or to support efforts to reduce the costs of diapers. While recent efforts to remove a sales tax have been defeated in several states (e.g., Louisiana, Maryland), California became the first to provide subsidies for diaper purchases to families already in some state assistance programs (e.g., CalWorks Welfare-to-Work, or Cal-Learn). However, a California proposal to remove the sales tax on diapers was not adopted. Eleven states (and the District of Columbia) do not apply a sales tax on baby or adult diapers, and feminine products and adult diapers are not taxed in two states.

Texas sales taxes are consistently a major source of revenue to both Texas and local governments, totaling about 25 percent of the state's revenue each year. The only higher source of revenues in the state is federal funds — about 35 percent of the annual total. Sales tax revenues can fluctuate based on pricing and consumer consumption and exemptions. A report from the Texas comptroller notes that 2017 fiscal year sales tax exemptions will total almost $42 billion. An exemption for an item that is TPP, such as diapers, can be approved only with a change in state statute, and local governments cannot elect to forgo their portion of a sales tax unless authorized by state statute.

Like other states, Texas has had proposals on the application of sales taxes on tangible personal products. House Bill 221 by Rep. Donna Howard (D-Austin) called for an exemption to the sales and use tax for child and adult diapers. HB 221 would have amended Sec. 151.313 of the Tax Code, which identifies the health care supplies exempted from a sales tax (e.g., drugs, medicines, hypodermic needles and syringes, braces, hospital beds, adjustable eating utensils). Legislation also was filed to remove the sales tax for feminine hygiene products (House bills 55 by Guillen/232 by Alvarado, 219 by Howard, and 410 by Springer/716 by Wu, and Senate bills 129 by Garcia and 162 by J. Rodriguez). None of these bills had a hearing.

Discussion

Texas does not have an administrative process for seeking a sales tax exemption, so approval of Resolution 305 would require state legislation (such as proposed by Representative Howard's HB 221). However, testifiers at the Reference Committee on Science and Public Health also noted that diapers were not the sole item of necessity that is taxed and that can present a cost burden for many. In addition, Texas does not have a general understanding or agreement on personal items that are basic necessity (e.g., toothpaste, soap, toilet paper). And, as Texas' annual budget relies heavily on sales tax revenues, seeking another exemption for diapers or any other product could call for the use of significant education and advocacy resources by TMA and other supporters. Moreover, efforts to expand an exemption could lead to the possibility of shifting or raising taxes on other items, or to reducing the expected revenue to the state — already a considerable concern, particularly related to state education and health care needs and costs in Texas.

With a large proportion of young children in the United States living in households with poverty, the material need for diapers is a tangible, ongoing concern for many young families and potentially for hundreds of thousands of adults who live at home and who live with incontinence, a disorder that can have a significant impact on health and well-being. Texas has one of the highest rates of poverty in the United States, with almost 1 million Texas residents living in poverty. Families experiencing diaper need are often at the lowest levels of income, functioning without public or private support. However, local and national organizations often rise to the challenge of providing resources for the neediest of families. Established in 1997 in San Antonio, the Texas Diaper Bank was one of the first to organize resources to aid children, people with disabilities, and seniors in need of diapers. In conjunction with the Texas Families Cluster of Care program, both the Texas Diaper Bank and the National Diaper Bank Network

also have been part of the volunteer response to hurricanes that have affected different parts of the United States this year.

While Texas has an outsized issue with growing populations with diaper need — children and the elderly — this is not solely a Texas issue or a physician issue. Such an effort would require extensive study and documentation of the need in Texas in collaboration with others.

Recognizing the importance of this substantial socioeconomic issue and the health needs of so many in Texas, the Council on Science and Public Health, in consultation with the Council on Legislation, offer the following recommendations in lieu of Resolution 305-A-17:

Recommendation 1: Encourage physicians to screen for social and economic risk factors in order to support care plans and to direct patients to appropriate local social support resources;

Recommendation 2: Provide information to members on community resources related to free and low-cost diapers and other basic material needs; and

Recommendation 3: Recognize diapers, especially for adults, are a basic and essential health care necessity that helps to mitigate disease and illness and enables many to remain at home, and support efforts to remove the state sales tax applied to diapers.

Related TMA Policy:
None

Related AMA Policy:
Tax Exemptions for Feminine Hygiene Products H-270.953. Our AMA supports legislation to remove all sales tax on feminine hygiene products.

Poverty Screening as a Clinical Tool for Improving Health Outcomes H-160.909. Our AMA encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources.

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REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSPH Report 3-A-18

Subject: Vitamin D_3 Supplementation (Resolution 320-A-17)

Presented by: David Lakey, MD, Chair

Referred to: Reference Committee on Science and Public Health

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Resolution 320, Vitamin D_3 Supplementation, was considered by the Reference Committee on Science and Public Health at TexMed 2017. Resolution 320 resolved (1) that TMA recommend universal initial cholecalciferol blood testing followed by testing twice yearly or more often, as directed by a physician; and (2) that TMA encourage the Food and Drug Administration and the National Institutes of Health to provide recommendations clearly defining the higher blood levels of 25-hydroxyvitamin D. The author of the resolution spoke of the significant and wide benefits his patients had attained with the routine intake of vitamin D_3. Opposition was expressed on the proposal to test asymptomatic persons, and noting physician concerns with supplementation, the House of Delegates supported referral. Resolution 320 was referred to the Council on Science and Public Health for consideration.

How Much Vitamin D?

Vitamin D is found in much of the food we eat and through exposure to sunlight. Vitamin D is a nutrient essential for the absorption of calcium and phosphorus to build and maintain strong bones throughout life. Vitamin D also has a role in other body systems such as the regulation of our immune and neuromuscular systems. And with an increased awareness of the role of vitamin D receptors in the body, the last decade has brought forward significant study on a potential association between vitamin D and a range of diseases such as Alzheimer's, asthma, heart disease, diabetes, and certain cancers.

The Food and Nutrition Board of the Institute of Medicine (IOM) develops the intake reference values for nutrients and the recommended dietary allowance (RDA) for vitamin D. The RDA is intended to meet or exceed the vitamin needs for at least 97.5 percent of the U.S. population. The current RDA intake levels for vitamin D are:

- 400 international units (IU) for infants/children aged 0-1 year;
- 600 IU for children, teenagers, and adults aged 1-70 years; and
- 800 IU for adults aged 71 or more years.

The IOM's RDA recommendations assume limited or no exposure to sunlight or poor or little skin exposure in many parts of the country.

The foods most Americans routinely consume generally are not found to be good sources of vitamin D. Many of the foods consumed by children and adults, such as milk, have been fortified with vitamin D and calcium. The 2015 Dietary Guidelines for Americans recommends that the "dietary pattern" for Americans include consumption of foods fortified with vitamin D (milk, yogurt, some fruit juices, fortified grains) and seafood with the highest amount of vitamin D (e.g., canned salmon or tuna, cooked sturgeon, mackerel, swordfish). Some protein foods (egg yolks, meat, nuts, seeds, certain oils, added sugars) also provide vitamin D, but dairy products typically represent the largest proportion of vitamin D in most diets.

Exposure to sunlight is a primary source for vitamin D, but it's unknown how much vitamin D most Americans get from exposure to sunlight, and there are no universal guidelines for how long a person should be exposed for the purpose of producing vitamin D. The amount of vitamin D a person's body can make is affected by factors such as geography, the time of day, cloud cover, the amount of skin, and the part of the body exposed. High melanin content will block intake as does the use of sunscreen. Yet, with the risk of overexposure to ultraviolet radiation, and sunburn and skin cancer, the American Academy of Dermatology does not recommend that natural sun exposure or tanning beds serve as a primary source of vitamin D for most, even with the use of sunscreen.

Whether it is consumed or a result of sun exposure, vitamin D is biologically inactive and must be activated to its active form, calcitriol. When a person is exposed to adequate sunlight, the synthesis of vitamin D begins when ultraviolet B (UVB) light reaches bare skin. UVB interacts with a precursor of cholesterol, 7-dehydrocholesterol, which stimulates the creation of the previtamin D_3 in the skin. When previtamin D_3 is transported to the liver, it is converted to 25-hydroxyvitamin D [25(OH)D] (calcidiol). The second process takes place in the kidneys, where it forms 1,25-dihydroxyvitamin D [1,25(OH)2D] (calcitriol), a hormone that is the active form of vitamin D. As vitamin D travels through the body, it binds to receptors throughout the body that can activate or suppress the immune system and functions in the body.

U.S. Vitamin D Status, Deficiencies, and Testing

The Centers for Disease Control and Prevention (CDC) conducts surveys of U.S. residents to assess health and nutritional status. For decades this has included studies that are part of the National Health and Nutrition Examination Survey (NHANES) to assess vitamin D status. The recent CDC estimates on vitamin D status by sex and race/ethnicity are highlighted in Figure 1 from the NHANES 2012 national report data. (*NHANES was conducted in 2015-16, but these data are not yet available for public study).*

Figure 1. Age adjusted mean 25(OH)D concentrations in the U.S. population (NHANES)

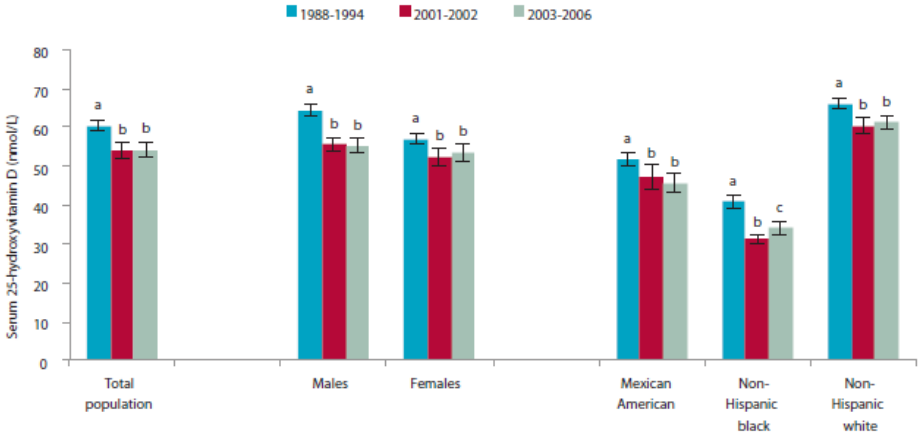

Figure H.2.b. *Age-adjusted geometric mean concentrations of serum 25-hydroxyvitamin D in the U.S. population aged 12 years and older by gender or race/ethnicity, National Health and Nutrition Examination Survey, 1988–2006.*

Error bars represent 95% confidence intervals. Within a demographic group, bars not sharing a common letter differ ($p < 0.05$). Age adjustment was done using direct standardization.

For the 2001-06 period, the concentrations of 25(OH)D in the U.S. population decreased over time. Non-Hispanic blacks had the lowest 25(OH)D, while non-Hispanic whites had the highest concentrations — supporting the understanding that vitamin D deficiency is strongly associated with race and ethnicity. Further, while 67 percent of the U.S. population had adequate serum 25(OH)D values, almost a quarter were at risk of inadequacy (serum 25OHD 30-49 nmol/L), while 8 percent were at risk of a vitamin D

deficiency (serum 25OHD less than 30 nmol/L), and 1 percent had a high serum 25OHD that could be harmful.

Testing for Vitamin D Deficiencies and Supplementation

IOM's committee on dietary reference intake for calcium and vitamin D agreed that almost all people had a sufficient serum 25OHD level of at least 50 nmol/L (20 ng/mL), but people with a serum 25OHD level below 30 nmol/L (12 ng/mL) were at risk of poor bone health. The committee also agreed that some were at risk of inadequacy at serum 25OHD levels between 30 and 50 nmol/L (12 and 20 ng/mL). Yet there is debate on the definition of vitamin D deficiency or inadequacy or insufficiency, with some studies proposing the IOM levels for a deficiency or inadequacy are too low, especially for certain populations. The clinical impact of a deficiency or insufficiency also will depend on other individual factors such as how long someone has been deficient and the person's physical activity levels, suggesting that serum values for vitamin D deficiency and insufficiency should be higher and that testing may be indicated for more people.

An adequate level of vitamin D is essential for the absorption of calcium for bone metabolism. Vitamin D deficiencies are attributed to factors such as poor intake of vitamin D from foods and or calcium, inadequate skin exposure to the sun, and high melanin content, or associated with conditions such as obesity or malabsorptive problems. The symptoms of a vitamin D deficiency are very general weakness or pain in the bones, or frequent infections, although some have no symptoms at all.

While testing for vitamin D deficiency is becoming more common in the United States, no medical organizations recommend universal screening of asymptomatic persons. The American Academy of Family Physicians has concluded the current evidence is insufficient to assess the balance of benefits and harms of screening for vitamin D deficiency. The U.S. Preventive Services Task Force (USPSTF) also found there is not a clear definition of vitamin D deficiency and insufficient evidence to determine if testing is either beneficial or harmful if a patient has no signs of a deficiency.

The accuracy of testing also is a concern for many clinicians, as there is a lack of agreement on the reference standard and the laboratory values for testing. It also is noted that laboratories use different assay methods, and this will affect test results and potential treatment.

Various organizations recommend targeted assessment of vitamin D deficiency risk for:

- Patients with hypercalcemia or decreased kidney function (Endocrine Society for Choosing Wisely, October 2013);
- Those with osteoporosis, problems with fat absorption, a history of bariatric surgery, or who take medications for certain conditions (Crohn's disease, celiac disease);
- Persons with darker skin or with obesity;
- Older populations, particularly if not active or if living in a long-term care facility;
- Infants who are breastfed without supplementation;
- Those whose social or religious affiliations require almost complete coverage of the body (e.g., traditional Muslim women can have undetectable levels of vitamin D);
- Those who have skin conditions that limit exposure to the sun (lupus);
- Those who chronically take medications that recommend limited exposure to sunlight (diuretics, sulfonylureas); and
- Those with fibromyalgia.

Several medical organizations make recommendations for consideration of vitamin D supplementation:

- As vitamin D deficiency or insufficiency commonly can occur during pregnancy, the American College of Obstetricians and Gynecologists recommends vitamin D supplementation for pregnant women considered to be at risk because a deficiency can have an impact on the health of the newborn. Lactating women and their infants also may be at higher risk of a vitamin deficiency, especially infants of a breastfeeding mother who is African-American.
- The American Geriatric Society recommends a review of dietary vitamin D consumption and sun exposure to reach a daily intake of 4,000 IU per day; this can include the consideration of a need for supplementation to reduce preventable bone fractures.
- The USPSTF has a "B" recommendation for vitamin D supplementation of community-dwelling adults 65 years or older if they are at increased risk for falls but does not make a recommendation for other populations, noting the evidence is insufficient to assess the balance of benefits.
- The American Academy of Pediatrics provides guidelines for both calcium and vitamin D intake through adolescence but also recognizes the need for different levels for children with obesity or on certain medications.

Safe Upper Limits of Vitamin D for Dietary Intakes for the General Population

Resolution 320 also recommended that TMA encourage the Food and Drug Administration and the National Institutes of Health to provide recommendations clearly defining the higher blood levels of 25-hydroxyvitamin D. IOM's recommendation on the upper intake levels for the daily dietary intake of nonprescription vitamin D are:

- 1,000 to 1,500 IU/day for infants;
- 2,500 to 3,000 IU/day for children 1-8 years; and
- 4,000 IU/day for children 9 years and older, adults, and pregnant and lactating teens and women.

For most patients, these upper limits would be considered quite excessive for routine supplementation. Most adults with mild insufficiency do well with 1,000 units daily, and only those who have morbid obesity or with severe malabsorption syndrome would require daily supplementation of 4,000 units. Patients interested in higher levels of supplementation should consult with their physician on the risks and benefits of increasing their intake.

Discussion

Medicine's interest in understanding the effects of vitamin D deficiencies has produced substantial study of the relationship between vitamin D with many chronic diseases and diseases of the immune system. The Cochrane database alone includes multiple systemic reviews of hundreds of studies associated with vitamin D and certain conditions. Additionally, with patients continually exposed to health messaging through advertising and social media, many patients want to be more involved in improving their own personal health and are seeking guidance from their physicians on dietary supplementation. However, while the critical link between vitamin D and bone health is well understood, the relationship between vitamin D and health status and health outcomes is not yet well established. Further, with much agreement still needed on vitamin D deficiencies and insufficiencies, physicians do not yet have clear guidance on how vitamin D supports the health of different populations and on the most effective methods of testing. While no national medical organization recommends universal screening, a universal screening recommendation in Texas — a large and diverse state with a burgeoning older population and more than 400,000 births a year — would substantially increase vitamin D testing and could portend a significant increase in the use of health resources and health care costs.

For those who are asymptomatic and would not be considered at risk, physicians need to be able to address patient inquiries on vitamin D. Physicians can ask patients about their dietary choices and sun

exposure for vitamin D intake and counsel patients on supplements. Patients should be informed that supplements are not medicines, and thus they are not regulated like medicines. Physicians can refer patients to the Dietary Supplement Label Database maintained by the National Institutes of Health, Office of Dietary Supplements, which maintains a searchable database on most of the supplements produced in the United States. For patients without a health risk for a deficiency, published information such as "Vitamin D Tests: when you need them — and when you don't," produced by the American Board of Internal Medicine and Consumer Health, is publicly available.

Physicians are committed to the practice of evidence-based medicine founded upon the highest level of clinical research and evidence to guide patient care. Much of the research on vitamin D includes important observational studies, but certainly extensive long-term studies would support guidance on who should be tested and when and how.

There is promise in further study of vitamin D to address the gaps in information on screening and testing of much of the population. Therefore, in lieu of adopting the resolves in Resolution 320, the Council on Science and Public Health recommends that TMA amend and adopt policy similar to AMA policy D-150.979 Appropriate Supplementation of Vitamin D D-150.979.

Recommendation: In lieu of Resolution 320-A-17, adoption of new TMA policy on Appropriate Supplementation of Vitamin D, as follows:

The Texas Medical Association will:

1. Support continued research on vitamin D, particularly long-term studies that address the benefits, adverse outcomes, and potential confounders across all life-stage groups;
2. Support monitoring of the evolving science of vitamin D and its impact on health and the development of resources for physicians about vitamin D for patients; and
3. Encourage physicians to consider measuring the serum concentration of 25-hydroxyvitamin D in patients at risk of vitamin D deficiency and counsel those with deficient or insufficient levels on ways to improve their vitamin D status.

Related TMA Policy:
260.102 Complementary and Alternative Medicine: (1) The Texas Medical Association will: (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) TMA will (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) TMA recommends 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 (CSPH Rep. 4-A-16).

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.

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.

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).

Related AMA Policy:

Appropriate Supplementation of Vitamin D D-150.979. Our AMA: 1. supports continued research on vitamin D and its metabolites, particularly long-term studies that address the benefits, adverse outcomes, and potential confounders across all life stage groups; 2. will educate physicians about the evolving science of vitamin D and its impact on health and develop resources about vitamin D for patients; 3. encourages physicians to consider measuring the serum concentration of 25-hydroxyvitamin D in patients at risk of vitamin D deficiency and counsel those with deficient or insufficient levels on ways to improve their vitamin D status; and 4. will monitor the development of new dietary references intakes for vitamin D in 2010 and respond as appropriate.

Medicare Reimbursement for Vitamin D Therapy for Dialysis Patients D-330.979. Our AMA will petition the Centers for Medicare and Medicaid Services and/or lobby Congress to defeat the "Vitamin D Analogs Draft Local Medical Review Policy" and to prevent its implementation in Florida or any other state.

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REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSPH Report 4-A-18

Subject: Implementing a Sugar-Sweetened Beverage Tax in Texas (Resolution 312-A-17)

Presented by: David Lakey, MD, Chair

Referred to: Reference Committee on Science and Public Health

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Resolution 312 by the TMA Medical Student Section was presented at the 2017 House of Delegates and called for TMA to support a Texas-wide sugar-sweetened beverage (SSB) tax. Testimony on the resolution in the reference committee was mixed, and the House of Delegates referred the resolution for study to TMA's Council on Science and Public Health and Council on Legislation.

As noted in Resolution 312, the intake of sugar-sweetened beverages is of concern to medicine and public health because of the prevalence of obesity in Texas and its association with SSB intake. Obesity, along with increasing chronic disease rates and health care costs, is not only a U.S. problem but also a concern throughout the world. With a 10-fold increase in child obesity over the past 40 years, the World Health Organization (WHO) identifies the reduction of SSB consumption during childhood as critical to stem further development of serious chronic conditions such as diabetes and liver disease — diseases that can demand the significant use of medical resources and can lead to long-term disability.

Consumption of SSBs

The definition of an SBB can vary, but the Centers for Disease Control and Prevention (CDC) describes an SSB as a liquid that has added sweeteners such as brown sugar, corn sweetener, corn syrup, fructose, glucose, and the like. Examples of SSBs are fruit drinks such as lemonade, sports energy drinks, and sweet tea, although the most commonly consumed SSBs in the United States are nondiet soft drinks. Texas statute does not include a definition of an SSB.

Revised in 2015, the Dietary Guidelines for Americans refer to a "healthy eating pattern" for adults and children that incorporates different types and amounts of foods including beverages. A healthy eating pattern limits foods and beverages with added sugars so that sugars make up less than 10 percent of calories consumed within a day, while allowing for consumption of noncaloric beverages (e.g., water, unsweetened coffee, tea) or more nutrient-dense beverages.

National surveys conducted to study the effects of behavior on health status include monitoring obesity and the consumption of SSBs. From the national Behavioral Risk Factor Surveillance Survey (BRFSS), CDC estimates that on average, about half of all adults and six out of every 10 children consume at least one SSB a day, or about 140-plus calories — calories that provide no or minimal nutrition to the body or an extra 1,000 calories a week. A January 2017 U.S. National Health and Nutrition Examination Survey report confirmed that almost 50 percent of adults 20 years old and older consumed at least one SSB a day, with males most likely to consume two or more a day (2011-14). Those who consumed the most were aged 20-29 years. Hispanic males and non-Hispanic black males had the highest mean caloric intake from SSBs, with non-Hispanic black women having the highest intake among females.

Almost 70 percent of U.S. youth (2-19 years) drink at least one SSB each day. Boys have slightly higher consumption (64.5 percent) than girls (62.9 percent). The total SSB caloric intake increases for both girls and boys as they grow older. Among boys, non-Hispanic white males, and among girls, non-Hispanic black girls have the highest mean caloric intake from SSBs.

SSBs and Weight Gain

Many studies have confirmed that the consumption of added sugars, and SSBs in particular, is associated with weight gain. The intake of added sugars has an immediate impact on the body, which responds by releasing insulin, followed by a decrease in the consumer's blood sugar level. However, the findings from these studies have been mixed, as many were small and time-limited, or they used different measures for weight gain or for SSB intake or different definitions of an SSB. Yet a 2013 meta-analysis of randomized controlled trials and cohort studies that used a WHO definition of dietary sugars concluded that for those who are not on a restrictive diet, the intake of SSBs and other free sugars has a substantial impact on body weight. Less intake of added sugars from any source results in less or no weight gain, while greater intake results in weight gain and adiposity, and can lead to metabolic disorders, although this overall result was not as clear among children. Other meta-analyses of studies on SSB intake describe how high SSB consumption in adults contributes to overweight and obesity and leads to higher risk for metabolic diseases. Malik, et al., reports that ongoing high consumption of added sugars from SSBs has various health effects such as beta cell dysfunction, insulin resistance, inflammation, visceral adiposity, and others. These responses can lead to increased disease risk for type 2 diabetes, cardiovascular disease, and metabolic syndrome.

While about 20 percent of U.S. daily caloric intake is from added sugars, consumers of SSBs typically do not adjust their diets to lessen it. In fact, with easy access, many drink SSBs to relieve thirst — not hunger or the need for an energy source. Over time, this dietary behavior contributes to the routine, high, and long-term intake of the liquid calories provided by the common sweeteners in SSBs (e.g., sucrose, fructose) — and eventually contribute to metabolic disorders.

Obesity in Texas

Obesity has been an ongoing concern in Texas, presenting a clinical and public health challenge similar to concerns with tobacco use. Texas has one of the highest rates of obesity in the United States. One of the first U.S. reports on overweight and obesity identified Texas' adult obesity rate in 1991 as 15-19 percent. In contrast, the 2016 Texas BRFSS showed that 33.7 percent of Texas adults over the age of 20 are obese, and 68.4 percent of Texas adults are overweight or obese. A third (33.3 percent) of Texas children aged 10-17 years are overweight or obese, while 15.9 percent of the Texas' children aged 2-4 years in the Women's Infants, and Children's nutrition program were identified as obese (2012).

The 2014 special report of the Texas Comptroller of Public Accounts (TCPA) on the cost of obesity in Texas attributed an estimated $11 billion of the 2012 costs to Texas businesses to obesity. TCPA projected that the cost of obesity to businesses would grow to $32 billion by 2030. While almost $4.6 billion of these business costs in 2012 were for health care, the costs of employee absenteeism, disability, and lost productivity and presenteeism represented the largest cost to Texas businesses.

Strategies to Reduce SSB Use

Awareness of the impact of SSB use in the United States has encouraged obesity prevention developments across the country:

- Federal nutrition guidelines and state and local policies have been developed with the intention of reducing SSB consumption. The most common strategies have been to restrict or prohibit SSB consumption and to limit portion sizes. Restricting the sale or prohibiting the consumption of SSBs in certain settings, such as schools, hospitals, and various workplaces, has been a popular approach in many states and cities, as well as in public and private workplaces. The Partnership for a Healthy America has led efforts to help hospitals and hospital systems (e.g., Kaiser Permamente, the Cleveland Clinic) promote consumption of noncaloric liquids and 100-percent fruit and vegetable juices, and limit access to SSBs and/or decrease the size of SSB portions. U.S. beverage

manufacturers now produce different SSB size options as well as offer water and other beverages with lower calories.

- There also have been efforts to reduce consumption in SSBs by increasing public awareness of the sugars and calories in these drinks, such as by labeling products. San Francisco was the first city to adopt an ordinance requiring warning labels on SSBs. However, the beverage industry succeeded in an injunction on the measure; the court expressed concerns with the first amendment rights of the beverage companies and concerns about the accuracy of the labels.

The most recent efforts to reduce SSB use have focused on adding a tax for each SSB purchase. This has become increasingly an interest of the public health community and particularly as a means to generate revenue to support public health obesity prevention efforts.

- In 2017, Philadelphia became the first large U.S. city to impose an excise tax of 15 cents per ounce on distributors of SSBs (and diet beverages), with a projection of raising more than $90 million in new tax revenues to the city. Revenues have been dedicated to prekindergarten programs, parks, and other public services.
- Berkeley, Calif., implemented a one-cent-per-ounce excise tax in 2015. One study noted that the price of SSBs increased in some settings, but this varied by type of purchase. Overall, there was a 9.6 percent decline in ounces of SSBs purchased, while the sale of nontaxed beverages, especially water, increased. Berkeley, however, already had a lower proportion of SSB consumers than the general U.S. population.
- Mexico, with almost 10 percent of the daily caloric intake of its adults and children from SSBs and a high rate of overweight and obesity (70 percent) and diabetes (9 percent), was the first country to adopt a nationwide excise tax on SSBs (one peso per liter, or about five cents), but others have followed. Initial reports on Mexico's SSB tax say SSB consumption has decreased, with health improvements expected over the next 10 years.

Texas Beverage Taxes and Projected Impact of SSB Taxes

Texas does not tax the purchase of nonprepared food products or products used to make foods for consumption (e.g., flour or sugar), but does apply a sales tax for certain foods and beverages such as candies and gum. While most beverages purchased in Texas are nontaxable, sales tax applies for beverages such as flavored waters, carbonated and noncarbonated soft drinks (whether sweetened with natural or artificial products), energy drinks, powdered drinks, and others. The Texas Legislature sets the 6.25-percent sales tax rate and determines which items to tax. In addition, local governments can assess a local sales tax of up to 2 percent. Sales tax collections vary each year but generally represent about 25 percent of total state revenue. Sales tax collections serve as general revenue for state and local government use.

Both the federal and Texas governments apply different types of taxes on "sin" beverages, generally based on the amount or volume of alcohol in the beverage and where the product is provided or sold. In Texas, these "sin" taxes are excise taxes. While excise taxes are not clearly outlined in state statute, an excise tax can be considered a value-added tax. Both the federal and Texas governments use value-added taxes to collect tax revenues; typically some others are tobacco, gasoline, and some hotel taxes.

The Texas Legislative Budget Board's 2013 report on government effectiveness and efficiency included a recommendation to add a consumption (user) fee of one cent per ounce of SSBs. Largely based on RAND studies on SSBs, the budget board also recommended dedicating revenues to treat, reduce, or prevent obesity. While several bills filed in 2013 proposed the taxation of SSBs (Senate Bill 493 and House bills 779, 735, and 751), none moved very far in the legislative process. HB 751, on the purchase of certain food items under the Supplemental Nutrition Assistance Program, would have prohibited the use of food

stamps to buy a sweetened beverage. HB 751 was passed by a House committee but was never scheduled for a vote by the full House.

Using the revenue calculator developed by the Yale Rudd Center, at one cent per ounce, if all taxes were passed through to the consumer, in 2018 Texas would collect excise tax revenues of $1.2 billion for more than 949 million gallons of sugar drinks sold.

Discussion and Conclusion

Overweight and obesity are a threat not only to individual health but also to public health and our Texas economy. The beverages we consume are now a key component of the U.S. diet, and for many, represent a substantial proportion of daily energy intake and a factor in personal health. The added sugars in SSBs are a particular concern for children and adolescents who at an early age readily initiate decades of consuming low-cost SSBs.

Texas has taken moderate steps to address overweight and obesity such as the Texas Department of Agriculture's restriction on access to SSBs in schools. Physicians also have access to child obesity education programs, for example, through Texas Health Steps (THS). Well-recognized for its offerings, THS could be a venue for more targeted physician education to support screening for child obesity and the promotion of healthy family eating and physical activity. There also are many other evidence-based programs and methods to prevent and reduce obesity, but funding is needed to support culturally appropriate local, state, and community programs and research**.** Even a small percentage of the projected $1 billion in revenues from an excise tax on SSBs could serve to invigorate obesity prevention efforts in every part of the state. This also could include additional funding over the coming decades to support physician screening and interventions in the primary care setting for children and adults at risk of cardiovascular disease and metabolic syndrome.

In a seminal report on the economic costs of obesity, EA Finkelstein, et al., framed obesity as an economic problem that grew rapidly in the 1970-80s because of its association with rapid technical advances that improved access to calorie-dense foods (and with lower pricing). At the same time, Americans were living in an "obesogenic environment' that no longer required high-energy expenditure by a large proportion of our population. Finkelstein argued that with federal and state governments assuming more of the rapidly increasing costs of obesity, public policy and actions to reduce behaviors to reduce overweight and obesity were important opportunities for government.

Finally, physicians and others concerned for the public's health must recognize that an additional tax on SSBs will not readily eliminate overweight or obesity. However, the experience in areas that have implemented SSB taxes suggests there will be some moderation in SSB use, although long-term outcomes are still unknown. However, an excise tax, when appropriately determined and dedicated to public health and clinical interventions for high-risk Texas populations, can be most effective if it is part of a broader effort to address overweight and obesity. Therefore, in recognition of the long-term risks and trends in obesity and obesity-related morbidity and in lieu of adopting the resolves in Resolution 312-A-17, the Council on Science and Public Health, in consultation with the Council on Legislation, offers the following recommendations.

Recommendation 1: That TMA collaborate with the public health community to promote and support evidence-based interventions that will reduce obesity and its complications. These evidence-based interventions should include providing information and resources for physicians to support obesity screening and diagnostic tools for use in the primary care setting, physician payment for the evaluation and management of patients with obesity, and research on culturally appropriate education and public awareness to address obesity and its complications.

Recommendation 2: Amendment of TMA Policy 260.095 as follows:

260.095 Eligibility of Sugar-Sweetened Beverages for the Supplemental Nutrition Assistance Program and Counseling: The Texas Medical Association 1) will ~~publish an~~ develop educational materials for~~educating~~ physicians to support their efforts to inform and counsel parents and their children about the effects of sugar-sweetened beverages (SSBs)~~,~~ and high-fat, -salt, or -carbohydrate foods on obesity and overall health~~, and 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 to extend local programs that multiply value for the purchase of fresh fruits and vegetables under SNAP; and 3) will work with both the Texas Legislature and the HHSC to remove SSBs from SNAP (Amended Res. 302-A-13).

Related TMA Policy:

260.093 Clinical Approaches to Obesity Prevention and Treatment: The Texas Medical Association will work to (1) identify current assessment practices of physicians to determine what tools are needed for them to address overweight and obesity in the care of their patients; (2) survey health plans to identify current coverage policies and reimbursement practices; (3) identify tools that health plans are using to assist patients, families, and physicians to better address overweight and obesity; and (4) collaborate with health plans on strategies for payment on obesity prevention and treatment to include conducting a pilot project with one or more health plans which will include payment for evidence-based approaches to assess and treat overweight or obese patients. TMA supports the necessary evaluation and research to optimize prevention, screening, diagnosis, and treatment of obesity in children and adults in the primary care setting and will work to develop the necessary tools and communications to assist physicians on covered preventive services including obesity treatment (CSPH Rep. 4-A-12).

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).

Related AMA Policy:

Taxes on Beverages with Added Sweeteners H-150.933 1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages containing added sweeteners. Taxes on beverages with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic.
2. Where taxes on beverages with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately effected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes.
3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages, particularly in children and adolescents.
4. Our AMA will: (a) encourage state and local medical societies to support the adoption of state and local excise taxes on sugar-sweetened beverages, with the investment of the resulting revenue in public health programs to combat obesity; and (b) assist state and local medical societies in advocating for excise taxes on sugar-sweetened beverages as requested.

Poverty Screening as a Clinical Tool for Improving Health Outcomes H-160.909 Our AMA encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources.

Strategies to Reduce the Consumption of Beverages with Added Sweeteners H-150.927 Our AMA: (1) acknowledges the adverse health impacts of sugar-sweetened beverage (SSB) consumption, and support evidence-based strategies to reduce the consumption of SSBs, including but not limited to, excise taxes on SSBs, removing options to purchase SSBs in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption, such as controlling portion sizes; limiting options to purchase or access SSBs in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; and (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and replacing SSBs with healthier beverage choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage choices for students.

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.

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 patients with obesity; (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 patients affected by obesity.

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REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSPH Report 5-A-18

Subject: Policy Review

Presented by: David Lakey, MD, Chair

Referred to: Reference Committee on Science and Public Health

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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:

45.011 **County Contracts to Recover Tissue in Texas:** Charges for tissue and organ collection should be limited to the recovery of operational costs and county contracts should limit charges to those costs (Amended CL Rep. 1-I-98 and Sub. Res 202-I-98; reaffirmed CM-BTU Rep. 2-A-08).

95.018 **Physician Pharmacy Interactions:** Pharmacy employees who are in contact by phone with physician offices should be properly trained in the nomenclature of prescription medications and protocols of handling and confirming physician prescriptions in order to minimize the risk of error in making these products available to patients (Amended Res. 29W, p 161A, A-98; reaffirmed CSA Rep. 4-A-08).

Recommendation 1: Retain

Upon review of the following policies, council consensus was to update the language to read as follows:

20.006 **Alzheimer's Disease and Other Dementia:** The Texas Medical Association:

1. Encourages physicians to make appropriate use of guidelines for clinical decisionmaking in the diagnosis and treatment of Alzheimer's disease and other dementias;
2. Encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;
3. Encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders;
4. Encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders;
5. Supports the use of evidence-based, cost-effective technologies with prior consent of patients or designated health care power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations;
6. Supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias;
7. Encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in

incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias;

8. Encourages physicians to promote regular physical activity, healthy eating, and management of cardiovascular risk factors (diabetes, obesity, smoking, and hypertension) to reduce the risk of cognitive decline and of dementia; and
9. Encourages physicians to discuss living wills, medical power of attorney, directive to physicians, and other end-of-life planning decisions with all appropriate patients ~~endorses the concepts of improving knowledge among physicians of the devastating effects of Alzheimer's disease and other dementia and endorses the concepts promulgated by the American Medical Association Council on Scientific Affairs regarding Alzheimer's disease~~ (Extracted CSA Rep. 4-I-98; reaffirmed CSA Rep. 4-A-08).

260.015 Firearms: ~~Firearm use and gun control are highly controversial issues in Texas and the United States.~~ The Texas Medical Association supports (1) the primary prevention of firearm-related morbidity and mortality through educating Texans about firearm safety and the potential hazards of firearm ownership ~~gun safety and responsible gun ownership~~; (2) the Texas Hunter Education and certification program developed by the Texas Department of Parks and Wildlife; (3) physicians in the clinical setting providing anticipatory guidance on the dangers of firearm ownership ~~responsible gun use~~ in an informational, nonjudgmental manner~~, while respecting parental decision-making~~; (4) strict enforcement of federal and state gun control laws and mandated penalties for crimes committed with a firearm, including illegal possession; ~~and~~ (5) the use of trigger locks (such as can be provided by www.projectchildsafe.org) and locked gun cabinets to help prevent unintentional discharge; and (6) unfettered study of issues involving firearms and public health and safety (Res. 28S, p 176, A-93; Substitute CPH Rep. 3-A-08).

260.058 Misuse ~~Labeling~~ of Ephedrine Products and Labeling: The Texas Medical Association supports ~~the~~ state and federal regulation of ephedrine products and the consistent labeling of products containing ephedrine, including the amount of active ingredients of drugs with pharmaceutical properties and accurate warning labels. With the ongoing challenge of substance misuse, TMA encourages continued state surveillance of ephedrine products to prevent a resurgence of methamphetamine use in Texas (Amended CPH Rep. 4-I-98; reaffirmed CPH Rep. 2-A-08).

265.018 Evidence-Based Medicine: The Texas Medical Association supports the use of science and well-designed, well-conducted clinical research as a foundation for good medical practice to improve the quality of patient care. Guidelines and protocols for medical care based on thorough reviews of current medical research can improve the consistency, timeliness, and efficiency of clinical care. National and international medical organizations as well as nursing and allied health continue to develop evidence-based guidelines and recommendations to improve patient care. At times, evidence is incomplete and involves expert opinion. However, popular, advertised trends are not identical to experts. The quality of the evidence to support guidance is graded on the strength of the data from which it is derived. Evidence-based guidelines are always supportive, not prescriptive, and should be adjudicated by the physician or provider with good medical judgment and experience in the best interest of the individual patient. TMA encourages continued medical research in areas where a gap in knowledge exists on which to base medical practice. TMA supports the use of evidence-based medicine to improve approval and payment for medical services where appropriate. ~~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.2~~

TMA strongly supports the standardization of a national set of evidence-based measures that are clinically meaningful and lead to performance improvement while improving both patient outcome and patient satisfaction such as those endorsed by the National Quality Forum. ~~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~~ professional standards, (2) whenever there is a significant ~~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 American Medical Association ~~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).

280.033 **Hypothermia for ~~Successful~~ Adult Out-of-Hospital Resuscitation:** The Texas Medical Association supports the concept and basic benefit of mild ~~induced~~ therapeutic hypothermia for successful out-of-hospital resuscitation, and will (1) work with multiple stakeholders to further evaluate current availability and possible risk-management issues surrounding this treatment modality, (2) ~~advocate for statewide policy, involving individuals engaged in direct patient care in every step of the policy development process, (3)~~ support research into the broader applicability of mild ~~induced~~ therapeutic hypothermia as it impacts other neurological disorders and support the development of a national registry to track data of such cases, and (~~4~~3) provide ongoing educational articles and seminars for members on this emerging treatment modality (CSA Rep. 2-A-08).

280.034 **Pain Management:** The Texas Medical Association ~~will~~: (1) supports more effective promotion and dissemination of educational materials for physicians on ~~prescribing for~~ pain management including the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain and the associated online training series for physicians and health care providers; and (2) recognizes that pain is a symptom; the cause should be identified and specific treatment tailored to the specific cause and pain type ~~take a leadership role in resolving conflicting state and federal agencies' expectations in regard to physician responsibility in pain management; (3) coordinate its initiatives with those state medical associations and national medical specialty societies that have already established pain management guidelines; and (4) will disseminate Council on Science and Public Health~~

~~Report 5 (A-06), "Neuropathic Pain," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain)~~ (CM-C Rep. 3-A-08).

Recommendation 2: Retain as amended

Council review of the following policies revealed that these are no longer relevant, and they are being recommended for deletion.

30.027 **Physical Therapy Services:** The Texas Medical Association, in keeping with current policy (see 30.018), opposes direct access for physical therapy services (CM-R Rep. 3-I-98; reaffirmed CSA Rep. 4-A-08).

95.028 **Multiple Schedule II Drug Prescriptions:** The Texas Medical Association supports clarification of the laws and rules of Texas to allow the writing of multiple Schedule II prescriptions up to an equivalent of a 90-day supply in conformance with the spirit of the U.S. Drug Enforcement Administration guidelines (Res. 305-A-08).

260.057 **Regulation of Ephedrine Products:** It is Texas Medical Association policy that (1) ephedrine and ephedrine alkaloids, whether naturally occurring or synthetic, have pharmacological properties which categorize them as drugs; (2) that the quality and quantity of data is sufficient to establish that ephedrine and its alkaloids are associated with serious adverse effects when consumed as dietary supplements or in OTC products; and (3) that regulations be promulgated to define naturally occurring and/or synthetic ephedrine and ephedrine alkaloids as prescription drugs; their use should be allowed only when supervised by a duly licensed physician on a prescription basis. Ephedrine and ephedrine alkaloids should be prohibited from nonprescription foods, dietary supplements or other OTC commercial products intended for public consumption (Amended CPH Rep. 4-I-98; reaffirmed CPH Rep. 2-A-08).

280.024 **Interagency Council for Genetic Services:** The Texas Medical Association supports the activities of the Interagency Council for Genetic Services through its sunset evaluation and supports establishment of rulemaking authority for the IAC under the Texas Department of State Health Services and that its activities be adequately funded (Amended CSA Rep. 3-I-98; reaffirmed CSA Rep. 4-A-08).

Recommendation 3: Delete

REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSPH Report 6-A-18

Subject: Physician Role in Increasing Vaccination for HPV

Presented by: David Lakey, MD, Chair

Referred to: Reference Committee on Science and Public Health

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Background

The first human papillomavirus (HPV) vaccine was licensed for use in females aged 9-26 years according to the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommendations in 2006, with updated recommendations for the use of the 9-valent vaccine in females and males in 2014. After 12 years of use in the general population of the United States and other countries worldwide, it has been established as a safe and effective vaccine that will prevent HPV-associated cancers in women and likely in men; yet, there has been a substantial lag in uptake in the United States, especially in certain states. The multi-specialty Texas Medical Association HPV Workgroup convened at the 2017 TMA Winter Conference, after David Lakey, MD, chair of the TMA Council on Science and Public Health, recognized the need for a well-coordinated effort among several TMA committees to increase the uptake of HPV vaccine in Texas. Important partners invited to participate in this effort included representatives of the ImmTrac2 group at the Texas Department of State Health Services (DSHS), Texas Pediatric Society (TPS), University of Texas (UT) System, Texas Health Improvement Network, MD Anderson Cancer Center, and the Texas Cancer Coalition/American Cancer Society. Face-to-face meetings of this workgroup occurred in January, March, July, and September 2017 and several teleconferences took place between April 2017 and January 2018.

Data from the 2016 National Immunization Surveys (NIS) Teen Survey were published in the Morbidity and Mortality Weekly Report (MMWR) on August 25, 2017 and summarized by the UT System Population Health Group in its recent report, *Missed Opportunity: Human Papillomavirus Vaccination*. These reports were disseminated to physicians in Texas and provide additional support for the work of this group. In summary, less than half (49.3 percent) of Texas adolescents aged 13-17 years had received one HPV vaccine in 2016. Texas ranks 47th (including the District of Columbia) in its HPV vaccination rate of teens, well below all but four other states in the country. The specific tasks for the HPV workgroup were to identify potential barriers to vaccination and develop strategies to improve HPV vaccination rates in Texas.

This report summarizes the obstacles identified and discusses evidence-based strategies for physicians and institutions to overcome these obstacles and increase the rate of HPV vaccination in Texas, thereby improving the health of Texans. While there is more work to be done by this HPV work group, the TMA Council on Science and Public Health will identify further steps in consultation with its committees.

Development of Goals of TMA's HPV Workgroup

The TMA HPV workgroup convened for the first time on Jan. 27, 2017, during the TMA 2017 Winter Conference. Work group members discussed the Texas Health and Human Services Commission (HHSC) HPV Strategic Plan released in December 2016. The work group evaluated whatever current Texas vaccination data could be obtained (2015 Teen Survey), data from groups who were engaged in studies, and were able to share the data they had collected. The following needs and barriers to increase acceptance of HPV vaccine by families and patients were identified by the work group:

a) A need to reframe the conversation about HPV vaccine to stress the role in prevention of cancer in females and males and to administer the vaccine at the same time as the state-required pre-teen doses of Tdap and MenACWY vaccine.
b) Lack of physician knowledge of the published safety and effectiveness data of HPV vaccine and data that demonstrate that receiving the HPV vaccine does NOT encourage sexual promiscuity.
c) A need for widespread dissemination of communication skills that have proved successful in dispelling the myths associated with the HPV vaccine and improving vaccine acceptance.
d) Overestimation of physicians of the reluctance of families to accept HPV vaccine for their sons and daughters.
e) Time required to discuss this vaccine with families who are in need of more information.
f) Importance of providing HPV vaccine in the medical home at the same time as the Tdap and MenACWY vaccines in order to ensure that many of the other recommended preventive medicine screenings and counseling are provided; obtaining HPV vaccine by pre-teens in a pharmacy is not an optimal public health approach.
g) Lack of a fully functional statewide immunization registry (ImmTrac2) for tracking vaccine data by practice or clinic and non-participation of physicians; such registries have proven to be critical components of achieving high statewide vaccination rates.
h) Lack of consistent physician tracking of their HPV vaccination rates within their practice or clinic. This can be accomplished via electronic medical record (EMR) systems or via a fully functional ImmTrac2 system. Many physicians are not sufficiently well versed in the function of the EMR to produce such reports.
i) Unfamiliarity of physicians with stories of men and women who have survived an HPV-associated cancer.

After several meetings, the work group developed the following goals for 2017-2018:

a) Develop and promote a robust, physician-curated, HPV Resource Center on the TMA website.
b) Develop an HPV Data Workgroup to identify data deficiencies and interventions as needed.
c) Coordinate TMA communications to provide members with tangible strategies to improve HPV vaccination rates.
d) Leverage stakeholder interest on improving HPV rates in Texas. This includes: Texas Health Improvement Network, American Cancer Society, MD Anderson Cancer Center, Texas Pediatric Society, Texas Academy of Family Physicians, DSHS/HHSC, the Texas School Nurses Association, etc.
e) Identify and disseminate best practices for HPV immunization rates focused on education, communication, vaccine delivery, and vaccine rate tracking. The most important factor in HPV vaccine acceptance is strong physician recommendation.
f) DSHS to share HPV county data with those epidemiologists responsible for immunization programs in their jurisdictions.
g) Explore development of novel programs to deliver HPV education and/or vaccine in schools and on college campuses through the Texas Health Improvement Network with TMA's Be Wise – Immunize^{SM} program.
h) Adopt the recommendations of this report as House of Delegates policy at TexMed 2018.

TMA HPV Data Group

Dr. Lakey appointed Jane Siegel, MD, Chair of TMA's Committee on Infectious Diseases, to lead the HPV Data Group. It was evident that with a goal of improving the HPV vaccination rate in Texas, a reliable data collection system was needed. Volunteers from the workgroup were asked to participate if they had an interest. The findings of the data workgroup included the following:

1) A priority of the HPV data group was to define capability of collecting state data and work with DSHS to develop interventions as needed. Establishing a validated baseline for HPV vaccination rates is necessary to measure effectiveness of interventions developed. When physicians review the vaccination rates in their practices/clinics, they are often surprised to see the results and are motivated to work at increasing those rates. A fully functional registry should have the capacity to generate physician-specific reports. DSHS launched the implementation of a new ImmTrac2 registry using the template that has been found to be very successful in Wisconsin, but many obstacles in Texas have been identified. It is anticipated that ImmTrac2 will be a fully functional state immunization registry.

   Although there has been much concern about the barrier of having an "opt- in" vaccine registry, Texas' high consent rate at birth of 94-96 percent and a consent withdrawal rate of <1 percent suggests that this should not be a significant obstacle to maintaining data on immunizations in children <18 years of age. Rather, it is the physician participation and the logistical details that need to be addressed in order to assure universal participation of physicians in the immunization registry. The top two priorities regarding consent are:
   i. Assuring that those children who have moved to Texas are consented for ImmTrac2 and that their historical vaccine data from their state of origin are submitted to ImmTrac2; and
   ii. Improving the consent rate for 18 year olds from the current 4.8 percent.

   Working with DSHS, especially on the immunization registry, is necessary to enhance the function of ImmTrac2 as our state registry. Standardization of methodology of data collection, analysis, and presentation is needed and will benefit from efforts made to collaborate with the various electronic health record (EHR) systems. According to TMA data, more than 70 percent of physicians use EHRs, and approximately nine EHR systems are the most commonly used. However, each EHR has a different way of interfacing with Immtrac2, which poses a challenge facing ImmTrac2 and its ability to upload data consistently.

2) Three clinics/practice networks in different locations in Texas were identified whose physicians had been tracking their HPV vaccination rates as part of funded studies and were willing to share their data for the purpose of determining feasibility. Lessons learned from the data collected at these locations include:
   i. It is feasible to track individual physician immunization rates at regular intervals within a clinic/practice network.
   ii. A clinic/practice network will benefit by designating an individual(s) to oversee the management of the EHR system to generate physician specific reports at regular intervals, to analyze trends, and to validate the interaction with ImmTrac2, including uploads, correction of rejections, consent for 18 year olds and for patients who have moved to Texas from other states. The latter group may be willing to consent since most have moved from states with functional immunization registries.
   iii. HPV vaccine acceptance rates are increased when:
      a. Communication skills developed for vaccine-hesitant families are used.
      b. HPV is bundled with Tdap and MenACWY vaccines.
      c. Vaccination status is reviewed at every patient visit.
      d. Needed vaccines are offered at all visits.
      e. The vaccine series is initiated at <15 years of age because only two doses will be required.
   iv. Education of all office/clinic staff is beneficial, especially of medical assistants (MAs), to assure consistent messaging to families.
   v. Understanding how to present data for trending vaccination rates will assist physicians in identifying areas for improvement.

Additional Findings and Suggestions of the HPV Workgroup

1) TPS has participated in a pilot Education in Quality Improvement for Pediatric Practice (EQIPP) program for Maintenance of Certification credit sponsored by the American Academy of Pediatrics. TPS recruited 11 pediatric practices to complete the EQIPP module that included an educational webinar on HPV vaccination and communication strategies and collection of baseline and post-educational HPV vaccination rates from twenty charts identified randomly. Of note, there was only a modest improvement because the participating physicians already were utilizing the recommended tools and had achieved approximately 80 percent HPV vaccination rate of at least one dose at baseline.

2) Physicians participating in these summer meetings of the HPV Data Group all agreed that becoming more aware and understanding the "big picture" of the state of HPV vaccination in Texas was very valuable. Drivers to improve data collection and gaps between physician daily practices and availability of data to measure effectiveness of interventions need to be identified.

3) Identifying a local community champion(s) who may serve as a resource and "cheerleader" for physicians has been helpful in some locations.

4) Physicians should be educated on tracking their vaccination rates. Experts on EHR systems may need to be involved.

5) Attention must be paid to recognizing the role of school nurses and school administrators in educating students and families, which is under investigation.

6) There is value in collaborating with other societies of physicians, e.g. family practice.

HPV Tools, Social Media, and Deliverables

TMA developed a physician-curated HPV Resource Center on the TMA website, located at www.texmed.org/HPV. The site includes links to a variety of educational materials, as well as tools for physicians to improve their vaccination efforts, such as: CDC toolkits, a customizable CDC power point titled, "You are the Key to Cancer Prevention," and stories told by both male and female survivors of HPV-associated cancers. This site will undergo periodic review with updates as needed. Copies of TMA's infographics over HPV is provided in Appendix A.

Physician leadership to advocate for the HPV vaccine with patients is critical. TMA should continue to educate physicians about the importance of following the ACIP recommended immunization schedule, along with utilization of EHR systems to track their own progress and to upload data into ImmTrac2. This will be part of TMA education efforts including the Texas Medical Association Foundation (TMAF)-funded social media campaign.

The $20,000 TMAF-funded campaign will occur in two communities—San Angelo and Tyler. The social media to be purchased will include Facebook, Instagram, and Spotify. The message is still in development but will frame HPV vaccination as cancer control for the college-age population and will announce the dates for a Be Wise – Immunize^{SM} Clinic. Advertisements are likely to be fifteen seconds and can be targeted by zip code. Typical social media metrics such as number of opens, click rates, etc., will be used to evaluate effectiveness. Two additional measurements will include where the student receiving the vaccination heard about the clinic, along with a count of the number of HPV shots administered. Each site has a local champion. For San Angelo, a spring festival in March will be the site of one of the clinic events. One hundred doses of the HPV vaccine have been secured in San Angelo. In Tyler, the Be Wise – Immunize^{SM} shot event will be held at UT Tyler and then again at Tyler Junior College. Two hundred

doses of HPV vaccine will be administered at these two sites. Both communities have strong local champions who will work with TMA to coordinate media, messaging, and the event.

Jason Terk, MD, TMA Council on Legislation, participated in a communication panel on Effective Communication: Talking to Your Patients in an Era of Fake News at the TMA 2018 Winter Conference.

The council makes the following recommendation to enable TMA to continue its commitment to reduce the preventable cancers associated with HPV.

Recommendation: Adoption of new TMA policy, as follows:

Physician Role in Increasing Vaccination for HPV: In an ongoing effort to reduce the burden of preventable cancers associated with human papillomavirus (HPV) in Texas, TMA will:

1. Continue to educate physicians, monitor, and support implementation of interventions to improve the rate of HPV vaccination per Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommendations using the following evidence-based strategies:
   (a) educate physicians, families, and patients on the key message that the HPV vaccine prevents cancer safely in women and men,
   (b) recognize that physicians are leaders within the community and are critical in improving HPV vaccination rates,
   (c) communicate that strong physician recommendation is the most important determinant of vaccine acceptance,
   (d) strengthen communication through the utilization of the principles of successful management of vaccine hesitancy, HPV cancer survivor stories, and local/regional champions,
   (e) establish consistency in the messaging over the HPV vaccine's importance, effectiveness, and safety among all clinical/practice physicians and staff,
   (f) utilize effective vaccine delivery strategies, which include reviewing the vaccine status of all patients at all visits, and using standing orders, simultaneous administration, i.e., "bundling" the vaccine with other vaccines, and school-based clinics,
   (f) track the progress of vaccine delivery through the utilization of EMR functions, surveillance/monitoring systems, regular performance reviews, and maintaining knowledge of the trends in the rates of HPV vaccine coverage and HPV-associated cancer;

2. Support the continued testing, development, improvement, and dissemination of effective HPV vaccine intervention research and reviewing and editing policy recommendations accordingly;

3. Continue active collaborations with the Texas Department of State Health Services to optimize the use of the state immunization registry with the goal of having it be fully functional, as defined by the CDC, and utilized by physicians in order to have a reliable method to measure HPV immunization coverage rates in the state. TMA will encourage development of data sharing agreements among groups that are collecting valid HPV vaccine coverage rate data until a fully functional immunization registry is implemented; and

4. Continue to collaborate both internally and externally with health stakeholders to leverage and improve HPV vaccination rates in Texas.

Related TMA Policy:
50.008 HPV Vaccination: The Texas Medical Association will (1) promote the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices recommendations on the use of

human papillomavirus (HPV) vaccine; (2) provide education and assistance to clinicians on strategies for implementing HPV vaccination in their practice; (3) promote increased clinician and community awareness on HPV, and HPV-associated cancers and diseases and the scientific data supporting vaccine safety and efficacy; and, (4) work with external stakeholders to promote routine vaccination and series completion for all adolescents and young adults (CM-CAH Rep. 1-A-10; amended CM-CAH Rep. 1-A-15).

Related AMA Policy:

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872: 1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.

2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.

3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

Human Papillomavirus (HPV) Inclusion in High School Education Curricula D-170.995: Our AMA will: (1) strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in both males and females, the causal relationship of HPV to genital lesions and cervical cancer, and the importance of routine pap smears in the early detection of cervical cancer; and (2) urge that students and parents be educated about HPV and the availability of the HPV vaccine.

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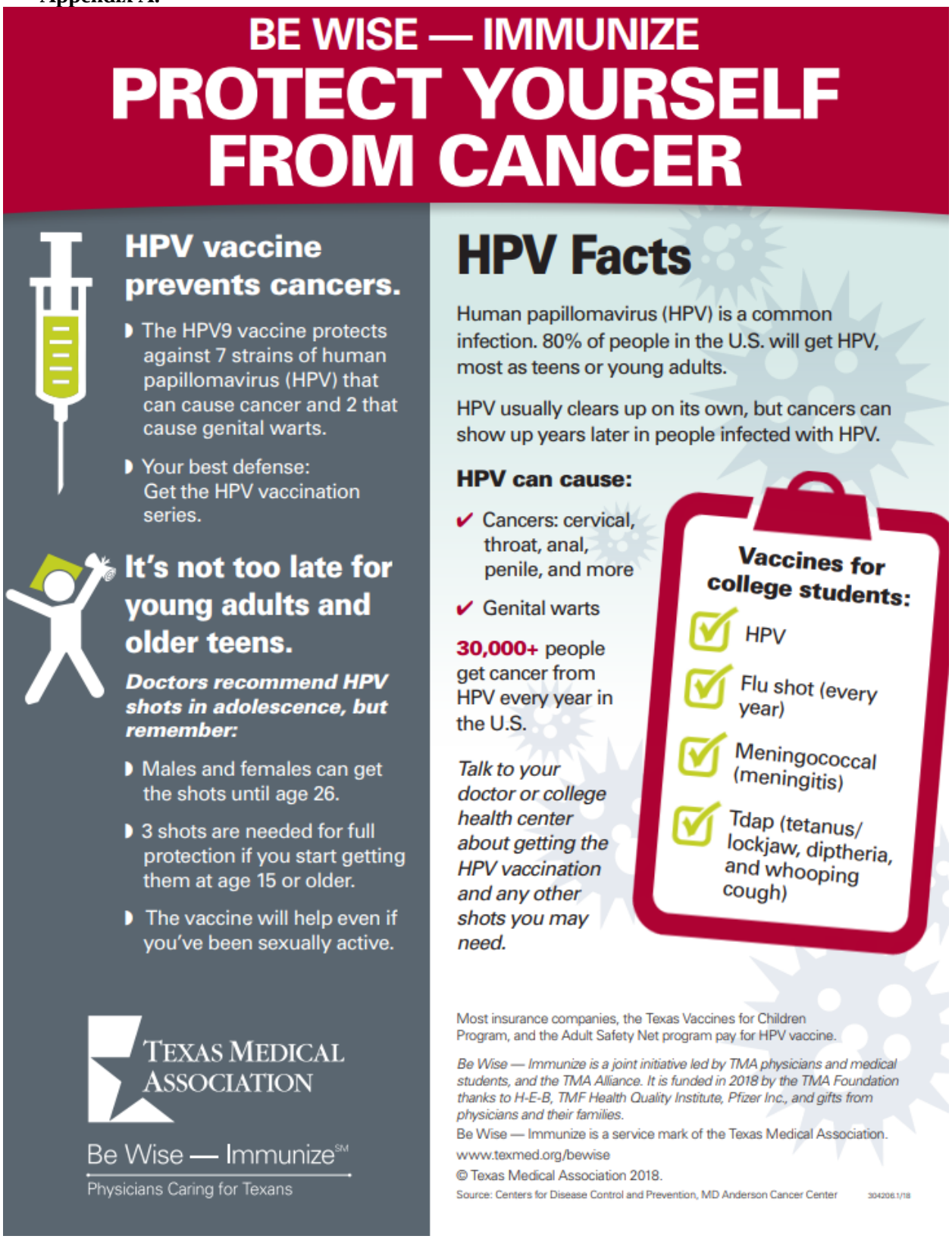
Appendix A.


BE WISE — IMMUNIZE
PROTECT YOURSELF FROM CANCER
HPV vaccine prevents cancers.
The HPV9 vaccine protects against 7 strains of human papillomavirus (HPV) that can cause cancer and 2 that cause genital warts.
Your best defense: Get the HPV vaccination series.
It's not too late for young adults and older teens.
Doctors recommend HPV shots in adolescence, but remember:
Males and females can get the shots until age 26.
3 shots are needed for full protection if you start getting them at age 15 or older.
The vaccine will help even if you've been sexually active.
TEXAS MEDICAL ASSOCIATION
Be Wise — Immunize℠
Physicians Caring for Texans
HPV Facts
Human papillomavirus (HPV) is a common infection. 80% of people in the U.S. will get HPV, most as teens or young adults.
HPV usually clears up on its own, but cancers can show up years later in people infected with HPV.
HPV can cause:
Cancers: cervical, throat, anal, penile, and more
Genital warts
30,000+ people get cancer from HPV every year in the U.S.
Talk to your doctor or college health center about getting the HPV vaccination and any other shots you may need.
Vaccines for college students:
HPV
Flu shot (every year)
Meningococcal (meningitis)
Tdap (tetanus/ lockjaw, diptheria, and whooping cough)
Most insurance companies, the Texas Vaccines for Children Program, and the Adult Safety Net program pay for HPV vaccine.
Be Wise — Immunize is a joint initiative led by TMA physicians and medical students, and the TMA Alliance. It is funded in 2018 by the TMA Foundation thanks to H-E-B, TMF Health Quality Institute, Pfizer Inc., and gifts from physicians and their families.
Be Wise — Immunize is a service mark of the Texas Medical Association.
www.texmed.org/bewise
© Texas Medical Association 2018.
Source: Centers for Disease Control and Prevention, MD Anderson Cancer Center
304206.1/18

BE WISE — IMMUNIZE
PROTECT YOUR CHILD FROM CANCER

HPV vaccine prevents cancers.

- The HPV9 vaccine protects against 7 strains of HPV that can cause cancer and 2 that cause genital warts.
- Your child's best defense: Get the vaccine in adolescence before being exposed to HPV.

All adolescents should get the HPV vaccine.

- Recommended for 11- and 12-year-old girls and boys.
- 2 shots before age 15 give full protection.

Older teens and young adults can get immunized, too.

It's not too late to start or finish getting the HPV shots.

- Males and females can get the shots until age 26.
- 3 shots are needed for full protection if starting them at age 15 or older.

Most insurance companies, the Texas Vaccines for Children Program, and the Adult Safety Net program pay for HPV vaccine.

Source: Centers for Disease Control and Prevention, MD Anderson Cancer Center

HPV Facts

Human papillomavirus (HPV) is a common infection. 80% of people in the U.S. will get HPV, most as teens or young adults.

HPV usually clears up on its own, but symptoms can show up years after getting infected with HPV.

HPV can cause:

- ✔ Cancers: cervical, throat, anal, penile, and more
- ✔ Genital warts

30,000+ people get cancer from HPV every year in the U.S.

Vaccines for your 11- & 12-year-olds:

- ☑ HPV
- ☑ Influenza (needed every year)
- ☑ Meningococcal (meningitis)
- ☑ Tdap (whooping cough)

Talk to your child's doctor about getting the vaccination.

TEXAS MEDICAL ASSOCIATION

Be Wise — Immunize℠

Physicians Caring for Texans

Be Wise — Immunize is a joint initiative led by TMA physicians and medical students, and the TMA Alliance. It is funded by TMA Foundation thanks to major gifts from H-E-B and TMF Health Quality Institute, along with generous contributions from physicians and their families.

www.texmed.org/bewise

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REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSPH Report 7-A-18

Subject: Evidence-Based Management of Substance Use Disorders

Presented by: David Lakey, MD, Chair, Council on Science and Public Health
Leslie Secrest, MD, Chair, Task Force on Behavioral Health

Referred to: Reference Committee on Science and Public Health

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The Council on Science and Public Health convened the Task Force on Behavioral Health to study and provide guidance and support to physicians caring for those with a behavioral health condition. One of the consistent behavioral health concerns is the state and national problem of substance use disorders.

The U.S. Substance Abuse and Mental Health Services Administration reports that more than 20 million U.S. residents (aged 12 or older) have a substance use disorder — a chronic disease of the brain that has an impact on and is a major source of morbidity, mortality, and community expense in Texas. Of those with a substance use disorder, almost 8 million also have a co-occurring mental disorder. Compared with most states, Texas has a low death rate associated with opioid overdose, and yet Texas had more than 2,800 opioid overdose deaths in 2016. The 2016 biennial report of the state's Maternal Mortality and Morbidity Task Force identified drug overdose as a leading cause of maternal deaths in Texas. And while most cases involved a combination of substances, illicit or licit opioids were detected in 58 percent of cases.

Alcohol remains the primary drug of abuse in Texas. Nearly one in three patients admitted into publicly funded treatment programs in Texas had a primary diagnosis involving alcohol. However, physicians should be aware that other substances continue to play a significant role in substance use morbidity and mortality. For example, methamphetamine use is an increasing problem in Texas. In 2016, there were more than 700 deaths due to methamphetamine in Texas, compared with around 500 from heroin. Additionally, the number of people admitted into treatment with a primary problem with benzodiazepines, especially Xanax, is increasing.

Recent literature outlines other factors influencing substance misuse, such as the following:

- Long-term use is not required to become addicted to medications. For example, a 10-day supply of opioids is enough to convert 20 percent of patients into long-term users; therefore, opioid dosage and treatment duration both should be as low as possible, typically three days or less, and rarely more than seven days. Another study found the quantity of pills prescribed for postsurgical acute pain could be reduced by 53 percent and less than 1 percent of patients required refills. And, there is evidence of a wide variation and excessive dosage of opioid prescriptions for common general surgical procedures.
- The development of dependence on benzodiazepines can follow high, normal, or even low-dose use of six weeks or more. Although commonly used for the treatment of anxiety disorder, benzodiazepines are not the treatment of choice. Instead, selective serotonin release inhibitors are generally considered to be the first-line pharmacological approach.
- Benzodiazepines should be reserved for treatment of patients who have not responded to at least three previous treatment strategies.
- Medical use of stimulants has increased steadily as the diagnosis of attention disorders has increased, and physicians should be assured of an accurate diagnosis before prescribing stimulants. Physicians

also should be aware of the risk factors for stimulant abuse and of the risks and protective factors for methamphetamine use and nonmedical use of prescription stimulants among young adults 18 to 25.

Texas is not recognized as having an opioid crisis, in contrast with other states where a crisis has been declared. Opioid use actually is trending downward since the rescheduling of hydrocodone. However, it is important to maintain a focus on the opioid use problems in Texas. For physicians and for public health to contribute to more effective management of substance use disorders, physicians should be informed about the evidence-based methods.

Physician Management of Substance Use Disorders

- Education and access to nonpharmacological management of pain and anxiety: Chronic pain is an epidemic in the United States. To manage all Americans with persistent pain, each practicing pain specialist in the United States would have to treat more than 20,000 patients. Therefore, all physicians need to understand evidence-based multidisciplinary treatment of chronic pain involving physicians and other health care professionals. For example, reduced (or no) copayments for physical therapy and other evidence-based nonpharmacological treatments might reduce medication use and improve patient functionality and outcomes.

  Likewise, effective nonpharmacological treatments for anxiety disorders are available, including psychosocial treatments such as cognitive behavioral therapy. These therapies have better long-term outcomes than medication. In addition, patients often prefer psychological treatment over medications.

  It is also important to note that many patients who present complaining of anxiety have symptoms associated with stressful life events, which often improve without needing any specific treatment.

- Universal screening of adolescents, pregnant and postpartum women, and adults for substance use disorders as part of their primary care: Early detection of substance use disorders may prompt patients to seek treatment and therefore reduce the possibility of significant disability and comorbidity, including overdose, poor work and school function, and medical complications. Therefore, it is critical for physicians to screen for substance use disorders and respond to patients who have them.

  The National Institute on Drug Abuse Modified Assist (for adults) and the Center for Adolescent Substance Abuse Research's CRAFFT tool (for adolescents) are examples of quick, easy-to-use screening tools. Significant reductions in alcohol and substance use can result when screening is followed by a nurse or social worker offering brief, evidence-based intervention at the same doctor visit. The American College of Obstetricians and Gynecologists recommends universal substance use disorder screening during routine preventive care visits as well as during the initial prenatal care visit, using a validated screening tool.

- Physician education on evidence-based medication-assisted treatment: Medication-assisted therapy -- not medically supervised withdrawal –is the preferred treatment methodology for opioid addiction. Buprenorphine/naloxone combination induction treatment, stabilization, and maintenance is the appropriate treatment for most patients. Pregnant women who are determined to be appropriate candidates for buprenorphine treatment should be inducted and maintained on buprenorphine monotherapy.

  For that reason, medication-assisted treatments like methadone, buprenorphine, and naltrexone should be routinely available in primary care settings for people with addiction to opioids. In addition,

initiation of induction in emergency departments, hospital inpatient services, and in the criminal justice system should be available.

A Public Health Role in Managing Substance Use Disorders

- Access to evidence-based treatment: In Texas, only about 3 percent of people in need of substance use disorder treatment are able to obtain treatment. Many people depend upon the criminal justice system to provide substance use services. In addition, it is not clear that the people who obtain state-funded substance use services are offered contemporary best practice models of care. **But, to be effective, substance use disorder treatment should address multiple needs of the patient.** Therefore, public- and private-sector treatment options should offer person-centered treatment planning inclusive of medication-assisted treatment when indicated and at least one of these evidence-based approaches: motivational interviewing, motivational enhancement therapy, cognitive behavior therapy, structured family therapy, contingency management, community reinforcement therapy, and 12-step facilitation.

  Because of their importance to outcomes, treatment planning should ensure availability of long-term, recovery-oriented housing and also transportation. Permanent supported housing and therapeutic communities are evidence-based options.

- Improved data collection on drug overdoses and fatalities and response to the data: Reliable information on drugs involved in overdoses and in deaths could help public health policymakers, as well as local law enforcement and emergency medical services, target interventions where they are needed most in a timely manner. Training of medical examiners statewide should focus on this need, and funding should allow for robust identification of drugs involved in deaths statewide.

  The state's Prescription Monitoring Program also could be used to identify trends and patterns of substance use disorders involving prescription medications. The database could show, for example, shifts in medication misuse which, in turn, could drive public health response.

- Harm reduction and access to illegally obtained drugs: Access to naloxone in opioid overdose in the community setting saves lives and is cost-effective. Nonetheless, barriers to its use remain, and so physicians should encourage the prescribing of naloxone to patients or family members of patients with risk factors such as use of high-dose or chronic opioid prescriptions, past or current use of illegal opioids, and recent opioid detoxification.

  There are differing opinions concerning when supported housing should be offered to adults with substance use disorders. Housing-First programs have no requirements for sobriety or treatment in order to receive housing, while others require abstinence for housing or make housing contingent on treatment. However, data indicate long-term supported housing has a positive impact on most outcomes.

  Increasing the cost and reducing the availability of illegal drugs leads to a decrease in their use. Therefore, it is important to support law enforcement efforts intended to reduce access to drugs and alcohol obtained illegally, especially by young people.

Discussion and Recommendations

The Texas Medical Association has little policy on substance use disorders, and much of current policy is quite out of date. Recent TMA policy addresses prescription drug abuse, but policy about the broader issue of substance use disorders is sparse.

Significant strides have been made in our understanding of the genetic and biological basis of substance use disorders, and contemporary treatments offer much hope for our patients and for the impact of these disorders upon our communities in Texas. Therefore, it makes sense to update Texas Medical Association policy to reflect contemporary understanding and contemporary treatment of substance use disorders. This involves adopting strategies for the public health system as well as guidance for physicians on the management of patients with substance use disorders. In that context, the Task Force on Behavioral Health and the Council on Science and Public Health recommend the adoption of new policy on the education of physicians on addressing the chronic disease of substance use disorders and on supporting public health initiatives to promote and provide access to publicly funded evidence-based care and treatment for those with these disorders, along with the deletion of Policy 25.008 Alcoholism.

Recommendation 1: Adopt the following as new policy: The Texas Medical Association believes that substance use disorders are complex diseases with biological, psychological, and sociological components, and that these disorders should be recognized and treated as are all other diseases. TMA believes that effectively addressing substance use disorders requires major initiatives for prevention, risk reduction, and treatment, inclusive of the following strategies for physician education and for improving public health programming to address these disorders in Texas.

1. Physician education on:

    a. The evidence-based prescription of addicting medications, especially benzodiazepines and opiates;
    b. The increased public- and private-sector access to nonpharmacological management of pain and anxiety;
    c. The goal of universal screening of adolescents and adults including pregnant and postpartum women for substance use disorders as part of their preventive and primary care; and
    d. Improving public- and private-sector access to evidence-based medication-assisted treatment for all substance use disorders for which such an intervention is clinically indicated.

2. Public health programming to:

    a. Improve public- and private-sector access to evidence-based treatment of substance use disorders, and aggressive, early linkage of patients in need;
    b. Support public health policymaker commitments to financing improved data collection on drug overdoses and fatalities and to a robust public health response to the data;
    c. Increase the availability of harm reduction measures for current users, including access to clean syringes, naloxone, and Housing-First recovery models; and
    d. Continue federal and local efforts to interrupt access to illegally obtained drugs.

Recommendation 2: Delete policy **25.008 Alcoholism:** The Texas Medical Association continues to endorse the AMA policy specifying that alcoholism and other substance abuses are complex diseases with biological, psychological, and sociological components, and that these should be recognized, considered, and treated as are all other diseases (Committee on Addictive Diseases, p 137, I-94; reaffirmed CPH Rep. 3-A-04; reaffirmed CSPH Rep. 2-A-14).

Related 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).

215.020 Funding for Mental Illness and Substance Abuse; No Closure of Psychiatric Hospitals. The Texas Medical Association advocates for improved funding for mental illness and substance abuse treatment and that funding for areas of the state be proportional to the service requirements of the area, and advocate that no psychiatric hospital beds be closed based solely on budgetary concerns in Texas (Res. 402-A-10).

245.014 Physicians and Substance Use Disorder: 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 Wellness to continue collegial communication and efforts with the Texas Medical Board.
4. Continue efforts to educate physicians regarding the distinct roles of PHW, the Texas Physician Health Program (TXPHP), and TMB.
5. Encourage county medical society-based PHW committees to advise physicians subject to monitoring or intervention that TXPHP may be available to such physicians who self-report. PHW 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.
6. Advise county medical society-based PHR 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; amended CM-PHW Rep. 4-A-17).

Related AMA Policy:

Substance Use and Substance Use Disorders D-95.984

Our AMA: (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders; (2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and
(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

Substance Use Disorders as a Public Health Hazard H-95.975

Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach;
(2) declares substance use disorders are a public health priority;
(3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction;
(4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and
(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.

Drug Abuse Related to Prescribing Practices H-95.990

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:
A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify “script doctors” and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to “duped doctors” and “dated doctors” so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.
B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.
2. Our AMA:

A. promotes physician training and competence on the proper use of controlled substances;
B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;
C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and
D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.
3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.
4. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances.

Drug Abuse in the United States - the Next Generation H-95.976
Our AMA is committed to efforts that can help prevent this national problem from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:
(1) supports cooperation in activities of organizations such as the National Association for Perinatal Addiction Research and Education (NAPARE) in fostering education, research, prevention, and treatment of substance abuse;
(2) encourages the development of model substance abuse treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;
(3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;
(4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration with the Partnership for a Drug-Free America in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;
(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Federal Office for Substance Abuse Prevention to continue to support research and demonstration projects around effective prevention and intervention strategies;
(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco dependence as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;
(7) affirms the concept that substance abuse is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and
(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction.

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REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSPH Report 8-A-18

Subject: Improving Electronic Health Records, Health Information Exchange, and other Health Information Technology Products to Address Issues of Sex and Gender

Presented by: David Lakey, MD, Chair, Council on Science and Public Health
G. Sealy Massingill, MD, Chair, LGBTQ Health Workgroup

Referred to: Reference Committee on Science and Public Health

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The 2017 House of Delegates considered several proposals related to improving health care associated with sexual orientation and gender identity (SOGI). This included a report from the TMA Board of Councilors to address Resolution 307 submitted by the Medical Student Section at TexMed 2016. Resolution 307 called for TMA to:

- 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 in patients' medical records, and to
- Support patient data collection that is inclusive of nonbinary gender identities, as it will allow for relevant medical research.

Testimony indicated broad support of the resolution; however, the 2016 House of Delegates referred the resolution due to the complexity of the issue, as well as the fact that some of this work already was underway at the federal level. The Board of Councilors considered Resolution 307 and recommended to the 2017 House of Delegates that the Council on Science and Public Health be charged with developing policy on the topic of patient gender and sex identity. The board's recommendation was amended to direct the council to provide recommendations to guide TMA activities related to gender and sexual diversity. The council subsequently appointed a workgroup on LGBTQ health, chaired by council member G. Sealy Massingill, MD. This report focuses on the charge to address gender and sexual identity options in electronic health records (EHRs); health information exchanges (HIEs); and other health information technology (HIT), such as e-prescribing and billing systems.

LGBTQ Health and Access to Care

The United States is in the early stages of its work in assessing the population size and characteristics of people who do not identify as being the sex they were assigned at birth, who do not identify as heterosexual, or who have medical or surgical conditions or changes related to sex and/or gender. Based on its recent surveys, the Centers for Disease Control and Prevention (CDC) estimates 1.6 percent of U.S. adults identify as gay or lesbian, while 0.7 percent identify as bisexual. A lower proportion of adults aged 65 or older identified as gay, lesbian, or bisexual. CDC also estimates more than 1 million U.S. adults identify as transgender, with a large proportion of these (85 percent) identifying as transgender female.

There is a growing body of study on the health disparities experienced by people who identify as lesbian, gay, bisexual, transsexual, queer, or questioning (LGBTQ). Although "LGBTQ" is the acronym currently used for these populations, individuals also may refer to themselves using other, less common terms. CDC has surveyed for common indicators of health, such as access to health care and health insurance status, for LGBTQ people. CDC reports that people who identify as lesbian, gay, or bisexual have a number of concerning health risk indicators, such as significantly higher rates of smoking, overweight and

obesity, depression, and anxiety than the heterosexual population. Lesbian, gay, and bisexual adults also are more likely to have alcohol and other substance use disorders than the general population. Access to care is a concern for lesbian, gay, or bisexual adults. For example, according to National Health Information Survey data, a lower proportion of adult females who identified as lesbian, gay, or bisexual had a regular place to seek medical care than did adults who identified as straight. This aligns with surveys noting that lesbian, gay, or bisexual adults are less likely to receive routine preventive health screenings for conditions such as hypertension, dyslipidemia, diabetes, and cervical or breast cancer. Transgender people in particular appear to be more likely to face barriers to accessing health care. Several community-based surveys identify higher rates of unemployment or job instability, thus complicating access to health insurance and health care and to routine and specialized care and treatment.

LGBTQ youth are especially vulnerable. LGBTQ youth are more likely to be homeless and are at increased risk of substance use disorders and suicide attempts than other youth. Pubertal manifestation of secondary sexual characteristics not matching one's gender identity can cause extreme stress to transgender adolescents. When caring for transgender and other LGBQ youth, physicians must balance the need for the patient's privacy with the need to educate parents and caregivers regarding how to care for and support these vulnerable children.

Discussion

The Institute of Medicine's 2011 report on the health of lesbian, gay, bisexual, and transgender people called for a strategic action plan at the national level to conduct research on the health status and experiences of this population. This included recommendations to standardize gender identity measures, as these were essential to developing a health research agenda on sexual orientation and gender identity. Many studies note a lack of data collection in the United States allowing for nonbinary gender identities in medical records. In 2015, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology first issued rules requiring that all certified EHR technology have the capacity to record, change, and access structured sexual orientation and gender identity data. Physicians report that currently many EHR vendors are implementing this requirement simply by putting standard checklists into their systems –- checklists that are known to reduce workflow efficiency and usability. There are no standards for HIEs or other HIT products with regard to usability, and insufficient attention has been given to creating, advocating for, and enforcing best practice standards.

Among other objectives, EHRs should enable physicians to manage the care of their patients more efficiently. The EHR should be accurate, complete, and have current information on each patient for use by the physician to support clinical decisionmaking. Such information supports stronger communication between the physician and the patient and more timely care — and should contribute to improved health outcomes.

Federal legislation and federal agencies have led efforts in the significant expansion and use of EHRs to manage patient care and to facilitate the exchange of health information. But EHRs, HIEs, and other HIT products historically have been deficient in the ability to handle all of the complexities related to sexual orientation and gender identity.

The solution is not simply asking patients their sexual orientation and gender identity. It is also important to record, use, and transfer complex data such as:

- Chromosomal make-up;
- Gender assigned at birth;
- Sexual preference;

- Medical and surgical interventions (e.g., gender-affirming surgery, delay of secondary sex characteristics, hormone therapy); and
- Name (or names) and pronoun preferences.

In addition, EHR, HIE, and HIT systems must be able to handle:

- Inconsistencies between gender identity and insurance requirements for filing;
- Inconsistencies in HIE where systems use different vocabularies and data constructs; and
- Specialized clinical decision support (e.g., a transgender female patient may have a prostate that requires the system to alert about screening and medical or surgical care not required in a cisgender female).

While not specific to the LGBTQ population, physicians need tools to effectively capture and report longitudinal changes in demographics, health, and health care interventions.

To date, most of the above has been poorly developed and tested in EHRs, HIEs, and other HIT products. Rather than relying on federal legislation and rules, which often are primitive and inefficient, physician informaticists must be deeply engaged at the national level to create the most efficient and effective approaches to these complex informatics concepts in EHRs, HIEs, and other HIT products. Solutions should be tested for effectiveness, efficiency/usability, and safety before being implemented widely. The onus for creation of functional EHRs, HIEs, and HIT products for all patients, including our LGBTQ patients, should rest with the creators of those products rather than the physicians or patients providing or receiving care. That said, the design, functionality, and usability requirements should be based on input from clinical informatics professionals and physicians who have direct experience in managing the care of these patients.

Some of the benefits of including and exchanging data and using tools that provide the appropriate information regarding all aspects of sex and gender are:

- Allowing the physician to have a complete social, medical, and surgical history for each patient;
- Helping prevent medical errors by encouraging more complete patient disclosure and enabling physicians to screen and treat disease as appropriate for all patients, independent of gender identity or sexual preference;
- Supporting clinical decision support algorithms (e.g., alerts and order sets) that help physicians to make the right choices for patients; and
- Supporting patient safety.

Conclusion and Recommendations

The collection, usage, and transfer of accurate demographic, medical, and surgical patient data in EHRs, HIEs, and other HIT products are critical to guiding the physician's care. Such information is the foundation for assessing and understanding a patient's health history, risks, and potential health care needs.

Physicians' responsibility to provide quality care to their patients is built in an environment that supports an open, safe, and confidential patient-physician relationship. Physicians caring for LGBTQ youth face a particular challenge as they must be able to build trust with both the minor patient and the parent(s) while seeking information and maintaining confidentiality. But multiple surveys indicate an accepting environment is essential for a physician and office staff to develop a strong relationship with patients who identify as LGBTQ. EHRs that include demographic elements for additional gender and sexual orientation options are a start, but much more work needs to be done to appropriately handle the

complexities of these patients. As the federal government has shown to be an inappropriate place to develop usable and efficient EHRs (as demonstrated by the meaningful use program), and as there are no federal standards for HIEs and other HIT products, in order to support a positive and strong impact on health, the council and its workgroup make the following recommendations:

Recommendation 1: That the Texas Medical Association work with the American Medical Association and leaders in the field of lesbian, gay, bisexual, transsexual, queer, or questioning (LGBTQ) health such as the World Professional Association for Transgender Health and the Gay and Lesbian Medical Association to develop requirements for electronic health records (EHRs), health information exchanges (HIEs), and other health information technology (HIT) products reflecting best practices that include the ability to support, capture, and provide easy use by physicians of the following information:

a. Current gender identity,
b. Gender assigned at birth,
c. Sexual orientation,
d. Name (or names) and pronoun preference,
e. Indicated health screenings,
f. Appropriate clinical decision support tools, and
g. History of gender-affirming surgery or treatment as part of past medical or surgical history.

These products also should incorporate effective privacy attributes, particularly for adolescents, and enable physician use of a longitudinal view of changes in demographics, gender identity, sexual preference, medical and surgical history, and past interventions.

Recommendation 2: That TMA and AMA continue to advocate for the rapid incorporation of best practice requirements into EHRs, HIEs, and other HIT products.

Recommendation 3: That TMA adoption the following policy opposing increased costs to physicians and patients for required updates of EHR and HIT systems:

Costs to Update EHR and HIT Systems: The Texas Medical Association believes that neither physicians nor patients should incur additional costs when electronic health records (EHRs) or health information technology (HIT) systems are updated to reflect the latest in regulatory requirements or evidence-based medical care in the area of lesbian, gay, bisexual, transsexual, queer, or questioning health

Recommendation 4: Adoption of the following as TMA policy on increasing physician awareness and removing barriers to LGBTQ health care access:

Improving LGBTQ Health Care Access: The Texas Medical Association recognizes that lesbian, gay, bisexual, transsexual, queer, or questioning (LGBTQ) individuals have unique health care needs and suffer significant barriers in access to care that result in health care disparities. TMA will provide educational opportunities for physicians on LGBTQ health issues to increase physician awareness of the importance of building trust so LGBTQ patients feel comfortable voluntarily providing information on their sexual orientation and gender identity, thus improving their quality of care. TMA also will continue to study how best to reduce barriers to care and increase access to physicians and public health services to improve the health of the LGBTQ population.

Related TMA Policy:
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.

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.

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; (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; (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) state adoption in statutory form of the "mature minor" doctrine and elimination of other statutory barriers to adolescents accessing health care; (b) 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 referral, skillful and understanding personnel working in a good facility, reasonable cost, and professional follow-up; (c) funding at the state and local levels to be established for student-oriented primary care clinics and/or school-linked comprehensive health care for adolescents; and (e) funding to 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; amended CM-CAH & TF Rep. 4-A-17).

265.021 Electronic Medical Records: The Texas Medical Association opposes compulsory adoption of an electronic medical record if it lacks an appropriate exemption process, and continues to support positive incentives for EMR adoption (Amended Res. 418-A-12).

265.012 Health Information Technology and Health Information Exchange (abbreviated): 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. … (Amended Res. 402-A-05; amended CPMS Rep. 3-A-07; substituted CPMS Rep. 2-A-10; amended CPMS Rep. 2-A-13; amended CPMS Rep. 1-A-14).

115.019 Abolish Compulsory Electronic Health Records: The Texas Medical Association recommends repeal of compulsory electronic health records and urges our Congressional Delegation to advocate repeal of compulsory electronic health records (Res. 414-A-15).

Related AMA Policy:
Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967. Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health.

National Health Information Technology D-478.995. 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.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

Information Technology Standards and Costs D-478.996. 1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards.

Health Needs of Lesbian, Gay, Bisexual and Transgender Populations H-160.991. 1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

Nondiscriminatory Policy for the Health Care Needs of LGBT Populations D-65.996. 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."

Sources:

1. Centers for Disease Control and Prevention, Sexual Orientation and Health Among U.S. Adults: National Health Interview Survey, 2013; Sexual Orientation among U.S. adults age 18 and over, 2014.
2. Centers for Disease Control and Prevention, HIV Among Transgender People, www.cdc.gov/hiv/group/gender/transgender/index.html, accessed Nov. 6, 2017.

3. Transgender Population Size in the United States: A Meta-Regression of Population-Based Probability Samples, *American Journal of Public Health*, February 2017.
4. Institute of Medicine Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. Washington (DC): National Academies Press (US); 2011.
5. Electronic medical records and the transgender patient: recommendations from the World Professional Association for Transgender Health EMR Working Group. Deutsch MB, et al. *J Am Med Inform Assoc* 2013;20:700–703. doi:10.1136/amiajnl-2012-001472.
6. Gay and Lesbian Medical Association and LGBT health experts. Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health. San Francisco, CA: Gay and Lesbian Medical Association, 2001.
7. Collecting Sexual Orientation and Gender Identify Data in Electronic Health Records, National LGBT Health Education Center, Fenway Institute.

REPORT OF COMMITTEE ON CANCER

CM-C Report 1-A-18

Subject: Policy Review

Presented by: Gerard Voorhees, MD, Chair

Referred to: Reference Committee on Science and Public Health

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TMA periodically reviews House of Delegates policies in the association's Policy Compendium for relevance and appropriateness. The committee's analysis and recommendation for retention, deletion, or amendment of policy is summarized in this report.

The following policy is recommended for retention:

50.004 **Skin Cancer Prevention:** The Texas Medical Association supports targeting childcare and school personnel for education on the importance of protecting children in their care from unnecessary sun and tanning bed exposure (Res. 29D, p 192, I-96; reaffirmed by Sub. CM-IS Rep. 4-I-98; amended CM-C Rep 2-A-08).

Recommendation: Retain

REPORT OF COMMITTEE ON CHILD AND ADOLESCENT HEALTH

CM-CAH Report 1-A-18

Subject: Policy Review

Presented by: Daniel Vijjeswarapu, MD, Chair

Referred to: Reference Committee on Science and Public Health

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TMA periodically reviews House of Delegates policies in the association's Policy Compendium for relevance and appropriateness. The Committee on Child and Adolescent Health's analysis and recommendations for retention, deletion, or amendment of policies are summarized in this report.

The following policies are recommended for retention:

55.052 **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).

260.034 **Lead Poisoning:** The Texas Medical Association supports childhood lead poisoning being a reportable health condition (Committee on Environment, p 94, A-95; reaffirmed CM-CAH Rep. 3-A-08).

Recommendation: Retain

REPORT OF COMMITTEE ON CHILD AND ADOLESCENT HEALTH

CM-CAH Report 2-A-18

Subject: Referred 2017 Resolutions Relating to Concussions and Head Injuries

Presented by: Daniel Vijjeswarapu, MD, Chair

Referred to: Reference Committee on Science and Public Health

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At the 2017 Annual Session, the House of Delegates referred Resolution 313, Improved Concussion Protocol to Reduce Psychological Morbidity in High School Athletes, and Resolution 314, Promoting Increased Awareness and Research for Grade School Soccer-Related Head Injury, to the Committee on Child and Adolescent Health. These resolutions are similarly related to concussions and head injuries, and call for TMA to support related legislation, share the resolution for consideration with the American Medical Association, and support education and awareness.

Both resolutions originated from the TMA Medical Student Section. Resolution 313-A-17 called for specific legislation related to assessments and psychiatric evaluation for high school athletes suspected of having a concussion. During the reference committee hearing, testimony was in favor of increasing awareness of brain injury and making sure TMA policy reflects the most current guidance. Members stated concerns about the specific recommendations in Resolution 313-A-17 and urged referral. Members also recommended that due to their close relation in subject, resolutions 313-A-17 and 314-A-17 be combined and considered together. The resolutions were referred for further review and consideration.

Current Law

In 2017, House Bill 3024 passed in Texas, effective in June. The bill adds to existing law (House Bill 2038, effective since 2011), which requires each school district to establish a concussion oversight team that includes a physician, requires athletes suspected to have sustained a concussion to be removed from practice immediately, and allows athletes to return to play only after being cleared by a physician. The new law clarifies that a student can be removed from a University Interscholastic League (UIL) practice or game should a qualified professional, or even a parent or coach, believe the student might have sustained a concussion. HB 3024 also authorized chiropractors similarly to other professionals, coaches, and parents to discern if a student might have sustained a concussion. These state requirements, however, apply only to UIL-sanctioned activities, and not to private schools, club teams, or recreational sports.

UIL, part of The University of Texas at Austin, provides guidance related to extracurricular, athletic, and music competitions, laying out academic and other eligibility standards for participation. Concussion monitoring and research is a priority for UIL, which is often referenced for guidance in this area. UIL recently added cheerleading to monitoring guidance after TMA adopted policy and at TMA's urging to ensure the activity also would have the concussion protocol applied in related injury situations. UIL requires submission of a Return to Play Form for any student athlete seeking to return to playing sports after a head injury or trauma. The completed form must be submitted to an athletic trainer or other person (who is not a coach) responsible for compliance with the Return to Play protocol established by the school district Concussion Oversight Team, and includes a requirement for evaluation and clearance by the treating physician. Additionally, UIL has created a Concussion Acknowledgement Form, which is required for all student athletes for grades 7-12 and must be signed by the student and parent prior to participation in athletics, as required by HB 2038.

In July 2015, the Texas Legislature's Sunset Advisory Commission authorized a collaboration between UIL and The University of Texas Southwestern Medical Center's Texas Institute for Brain Injury and Repair. The collaboration would develop one of the first statewide concussion registries in the United States. The project aims to document and track concussion incidence, examine injury characteristics, and identify risk factors among school-aged athletes. The goal of the project is to develop a state-of-the-art database that captures information about concussion injuries from voluntary participants in all UIL schools. This database will allow for quarterly reporting of statistics related to concussion across Texas to UIL and monitoring of concussion trends over time, and will set the stage for future research questions to be addressed. TMA has committed to supporting stronger oversight, including requirements for safety training and certification, strengthening injury surveillance, promoting educational programming, and encouraging physicians to get involved in local development of policies and strategies for injury prevention.

Concussion Legislation in Other States

Many states aim to prevent and diagnose traumatic brain injuries (TBIs), and to respond and rehabilitate TBI patients. In 2011, more than 55,000 high school football players and 29,000 young soccer players sustained concussions (a type of TBI) during practice or competition. Since 2007, state legislatures in all 50 states and the District of Columbia have enacted legislation to address youth sports-related concussion.

Data

TBI is defined as a bump, blow, or jolt to the head that disrupts the normal function of the brain. Not all trauma results in TBI; however, most TBIs are mild and are commonly referred to as a concussion. Participation in contact sports can lead to increased incidences of concussions. Nine percent of all high school football players may receive a sports-related concussion during their time in organized sports, and data indicate numbers are rising among middle school athletes, with 4 million to 5 million concussions in athletes occurring annually. Research suggests concussions in high school athletes are frequent and often underreported by athletes and supervising adults, with data indicating capture of only one out of every nine concussions. Among those reported, however, data indicate that 40 percent of high school athletes with an initial concussion will incur a second concussion. Additionally, 33 percent of high school athletes who have had a sports concussion report two or more in the same year. Concussions represent almost 10 percent of all high school athletic injuries and close to 6 percent of all collegiate athletic injuries, and rates of concussions are highest in students playing football and soccer. In high school sports played by both sexes, compared with boys, girls sustain a higher rate of concussions, and concussions account for a greater proportion of total injuries. In all sports, collegiate athletes have higher rates of concussion than high school athletes, but concussions represent a greater proportion of all injuries among high school athletes.

Suspected concussive injuries often receive inadequate attention, which can lead to damaging long-term consequences. Concussed high school and college athletes display significantly higher depression scores more than two weeks post-concussion. Adolescent patients who report sleep disruption after sports-related concussions report a greater number of concussion symptoms during their recovery. High school athletes with a history of two or more concussions have been shown to have significant, prolonged neuropsychological effects, and evidence links concussions in adults with long-term risk of suicide, up to three times the population norm.

With respect to age, participants younger than 15 years old tend to have a higher relative injury risk and greater prevalence of injuries compared with older players. The U.S. Consumer Product Safety Commission, through its National Electronic Injury Surveillance System, estimated there were 186,544 soccer-related injuries in 2006, including contact and noncontact injuries. Approximately 80 percent of these injuries affected participants younger than 24 years of age, and approximately 44 percent occurred in participants younger than 15.

The most frequent cause of concussion among college soccer players was contact with another player's head, elbow, or foot; less frequent causes of concussions were contact with the ball, ground, or goalpost, or contact with combinations of objects. Efforts to reduce potential head injury from purposeful heading (using one's head to hit and aim the soccer ball) are warranted. Proper heading techniques, the appropriate age at which to initiate teaching of purposeful heading, and characteristics of the soccer ball have been studied as a means to reduce head injury.

Current Guidance

The 5th International Conference on Concussion in Sport consensus statement recognizes the data around sport-related concussion (SRC) are constantly evolving, and management and treatment is at the behest of informed clinical judgment. Sport-related concussion represents the immediate and temporary symptoms of TBI. However, this definition does not provide clarity on the levels of impairment, grades of severity, or persistence of symptoms. The consensus statement concludes the term "concussion" often is imprecise and indistinguishable from TBI. Consensus for the definition of SRC includes these features: cause from a direct blow to the head or with enough force elsewhere on the body to affect the head, and rapid onset of neurological symptoms that resolve spontaneously, may result in neuropathological changes, and will range in clinical signs and symptoms that may or may not involve loss of consciousness.

SRC often is considered among the most complex injuries in medicine to diagnose and manage, as it can occur without loss of consciousness or discernable signs. Currently, clinicians have no precise diagnostic test. Therefore, as TMA policy supports, it is recommended that in cases where concussion is suspected, the athlete should be removed from the game and assessed by a physician. To assess attention and memory function, brief neuropsychological tests have been shown to be practical and effective. The most well-established and rigorously developed is the Sport Concussion Assessment Tool — 5th Edition (SCAT 5), while orientation questions about the time and place are unreliable in comparison.

However, these assessments are not meant to take the place of a complete clinical evaluation, or as the only tool used for treatment planning. Further assessment should take place in a distraction-free environment with more thorough evaluation tools. After a physician has ruled out concussion on the sidelines of an athletic event, the physician can determine when and what limitations the athlete must adhere to before a return to play. The need for follow-up assessment is critical as athletic events and sports games often are held in a chaotic environment, making initial evaluation challenging, and furthermore, there can be delayed presentation of symptoms not necessarily predictable during an on-field assessment. Diagnosis involves an array of assessments including clinical symptoms, physical signs, balance and cognitive impairment, behavioral changes, and disruptive sleep, and also should include a detailed concussion history. If a patient has one or more of these presentations or symptoms, SRC is likely and should be addressed with further evaluation.

5th International Consensus Conference on Concussion in Sport Graduated Return-to-Sport Strategy

Consensus statement

Table 1 Graduated return-to-sport (RTS) strategy

Stage	Aim	Activity	Goal of each step
1	Symptom-limited activity	Daily activities that do not provoke symptoms	Gradual reintroduction of work/school activities
2	Light aerobic exercise	Walking or stationary cycling at slow to medium pace. No resistance training	Increase heart rate
3	Sport-specific exercise	Running or skating drills. No head impact activities	Add movement
4	Non-contact training drills	Harder training drills, eg, passing drills. May start progressive resistance training	Exercise, coordination and increased thinking
5	Full contact practice	Following medical clearance, participate in normal training activities	Restore confidence and assess functional skills by coaching staff
6	Return to sport	Normal game play	

NOTE: An initial period of 24–48 hours of both relative physical rest and cognitive rest is recommended before beginning the RTS progression.
There should be at least 24 hours (or longer) for each step of the progression. If any symptoms worsen during exercise, the athlete should go back to the previous step.
Resistance training should be added only in the later stages (stage 3 or 4 at the earliest). If symptoms are persistent (eg, more than 10–14 days in adults or more than 1 month in children), the athlete should be referred to a healthcare professional who is an expert in the management of concussion.

Should an athlete be suspected of having a concussion, protocol stipulates that appropriate evaluation must take place at the time of injury, and athletes can return to play at physician discretion or should be removed from play and monitored for ongoing evaluation, depending on the injury. Reevaluation should take place to determine the presence of any further deterioration or changes in function.

Neuropsychological assessment is another recommended tool for concussion management by physicians, ideally prior to the athletic season for a baseline and for post-injury management. However, as with SCAT 5, it should be used in conjunction with other assessment tools to diagnose and manage SRC.

Rest is one of the most widely recommended interventions for SRC, and most consensus statements and agreements recommend rest until athletes are free of symptoms. Should an athlete require additional treatment or therapy for an injury, supported interventions include psychological rehabilitation and physical therapy. For persistent symptoms, current literature recommends a referral for individualized and targeted medical care, and if pharmacological therapies have been used during recovery, patients should be free of all concussion-related symptoms off medication before returning to play. Clinical recovery is defined as a symptom-free return to normal activities including school, work, and sports; however, individualized clinical judgment ultimately defines safe management and return-to-play decisions.

Summary

Members reviewed and discussed the resolutions related to concussion and head injury during the House of Delegates proceedings. In lieu of adopting new policy, the resolutions were recommended for consideration together because relevant policy exists in the TMA Policy Compendium. Members discussed making recommendations that highlight the adoption of age-based and well-defined, evidence-based policy on concussions. Members support a need for ongoing research and advise physicians to follow the most recent guidelines, and support education and awareness about head injuries. Members identified the TMA policy on cheerleading as robust and suitable for updating to include timely guidance and additional sports and athletics.

After review, the committee does not approve adopting the resolves due to redundancies in existing policy. There was consensus in the committee review that head trauma safety and awareness guidance and policy should be promoted in all sports, and any action by the committee should include a recommitment to providing information to physicians. Providing education is increasingly important as data and guidance are constantly evolving in this area. Guidelines are updated based on the evolving science and continued evidence-based research, and consistently define how physicians are advised to diagnose, treat, and manage concussion and head trauma. The resolution language mentions psychological assessments, and while members agree these are an important component of concussion treatment planning, recommending the assessments in policy is inappropriate because some family and pediatric physicians have no access to sports medicine specialists in their area.

Members discourage pursuing policy or action related to legislation, and do not wish to promote legislation unless related to requirements for education of student athletes. Legislation related to concussion and head injury can become outdated quickly. As research evolves, policy or legislative intervention might only hamper or perpetuate outdated information. Supporting up-to-date education in this area will ensure timely information is required and supported.

The Committee on Child and Adolescent Health recommends expanding current TMA policy on cheerleading head injuries and concussions to a more comprehensive policy not limited to only one sport and capturing SRC recommendations. In addition, the committee recognizes that while athletic trainers and coaches are required to complete two continuing education credits on concussion management every two years, teachers, athletes, and parents are not receiving ongoing education on this topic.

Therefore, in lieu of adopting the resolves in resolutions 313-A-17 and 314-A-17, the committee makes the following recommendations:

Recommendation 1: Amend policy 260.094, Cheerleading Head Injuries and Concussion as follows:

260.094 ~~Cheerleading~~ Head Injuries and Sport-Related Concussion (SRC): The Texas Medical Association 1) advocates for stronger University Interscholastic League (UIL) oversight of ~~cheer~~ student athletic programs in Texas. Oversight should include requirements for safety training and certification for coaches and safety and technique training for ~~cheerleaders~~ athletes in line with national guidelines; 2) will work with external groups, including UIL, to strengthen injury surveillance in Texas including monitoring ~~cheerleading injuries~~ sport-related concussion and identify high-risk activities; 3) promotes educational programming for students, coaches, and physicians on sport-related 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. TMA will continue to monitor developments on sport-related concussions; offer continuing medical education in various formats on concussions as indicated; and encourage physicians to contribute to and support updates of pediatric guidelines, providing the most recent information to TMA members (CCAH and CSPH Joint Rep. 2-A-13).

Recommendation 2: That TMA create a network in which TMA members could provide and receive consultations on concussions with one another, and possibly link physicians with specialists in sports medicine, as the best way to share information on concussion protocol, current knowledge on how to manage patients, and information for patients.

Recommendation 3: That TMA start an education and awareness campaign directed toward athletes to ensure education and timely information is shared directly with students.

Sources:

1. Concussions and Concussion Management Protocol Requirements and Information. University Interscholastic League. www.uiltexas.org/health/concussions.
2. Texas Sports Concussion Registry. The University of Texas Southwestern Medical Center. www.utsouthwestern.edu/research/brain-injury/research/con-tex.html.
3. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention.
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5. Fralick M, Thiruchelvam D, Tien HC, Redelmeier DA. Risk of suicide after a concussion. *CMAJ : Canadian Medical Association Journal*. 2016;188(7):497-504. doi:10.1503/cmaj.150790.
6. Committee on Sports-Related Concussions in Youth; Board on Children, Youth, and Families; Institute of Medicine; National Research Council; Graham R, Rivara FP, Ford MA, et al., editors. Sports-Related Concussions in Youth: Improving the Science, Changing the Culture. Washington (DC): National Academies Press (US); 2014 Feb 4. 1, Introduction.
7. Boden BP; Kirkendall DT, PhD; Garrett WE. Concussion Incidence in Elite College Soccer Players. *The American Journal of Sports Medicine*. Vol 26, Issue 2, pp. 23-241. First Published March 1, 1998.
8. McCrory P, Meeuwisse W, Dvorak J, et al., *Br J Sports Med,* Published Online First: [30 Oct. 2017]. doi:10.1136/ bjsports-2017-097699.

REPORT OF COMMITTEE ON INFECTIOUS DISEASES

CM-ID Report 1-A-18

Subject: Policy Review

Presented by: Jane Siegel, MD, Chair

Referred to: Reference Committee on Science and Public Health

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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 committee recommends amending the following policies:

95.019 **~~Needle~~ Syringe ~~Exchange~~ Services Programs (SSPs):** The Texas Medical Association ~~(1) maintains that any~~ supports SSPs as an important evidence-based harm reduction strategy among persons who inject drugs (PWIDs) and as an important component of plans to fight against the opioid epidemic. SSPs should be considered a public health intervention aimed at reducing transmission of blood-borne viruses, including HIV and hepatitis C, and that assist PWIDs to obtain treatment and cease using illegally-obtained intravenous drugs. TMA also recognizes that strategies such as SSPs offer a public health benefit by preventing the transmission of infections such as HIV and hepatitis C, resulting in substantial cost savings to government.

TMA also supports: (1) advocating for the elimination of legal barriers to implementing SSPs that are aimed at reducing blood-borne infections and encourages physician education on the evidence of positive health outcomes and cost-effectiveness associated with SSPs; (2) maintaining that any harm reduction strategy among PWIDs ~~IV drug users~~ should include a recommendation to cease drug use and the provision of effective treatment~~. If cessation cannot be achieved, education about the value of clean needles and syringes and information about needle exchange can be useful~~; (~~2~~(3) encourages the implementation ~~application~~ of SSPs ~~needle and syringe exchange and distribution programs~~ at the community level; (~~3~~(4) supports legislation that facilitates SSPs ~~for needle exchange programs~~; and (~~4~~(5) will educate its members on the scientific studies relating to SSPs ~~needle exchange programs~~ (CM-ID Rep. 4-I-98; reaffirmed CM-ID Rep. 1-A-08).

135.007 **Immunization Guidelines:** The Texas Medical Association encourages and supports frequent and regular dissemination of the ~~Uniform Childhood~~ Immunization Schedules for Children and Adolescents Aged 18 Years or Younger and for Adults Aged 19 or Older, which are updated annually and posted on the Centers for Disease Control and Prevention website (www.cdc.gov/vaccines/schedules/hcp/index.html), ~~recommendations~~ through appropriate media and other means of communication throughout Texas (Amended Res. 28O, p 141, A-95; reaffirmed CPH Rep. 2-A-08).

135.016 **Influenza and Tdap Vaccine Recommendations for Health Care ~~Workers~~ Personnel:** The Texas Medical Association: supports 100-percent influenza vaccination among health care ~~workers~~ personnel, i.e., all employees of health care facilities with direct patient care contact. Health care personnel ~~workers~~ opting to decline influenza vaccine offered by the

employer should be required to sign a declination waiver to be included in the personnel file. The waiver should include educational information about the danger of vaccine refusal ~~nonimmunization~~ and the potential spread of influenza among patients and family members. While all licensed health care facilities in Texas must have a policy on influenza and other vaccination for health care personnel, the decision to mandate influenza vaccination as a condition of employment is an individual facility decision.

TMA ~~S~~supports the Advisory Committee on Immunization Practices (ACIP) policy recommending that all health care personnel ~~workers~~ who have direct patient care contact in hospitals or clinics receive ~~get~~ a dose of tetanus-diphtheria-pertussis vaccine (Tdap). This recommendation should be extended to long term care facilities that are experiencing an outbreak of pertussis. A two-year interval since the last tetanus-diphtheria vaccine (Td) is suggested but not required. TMA recommends that employers assess for, administer, or secure a declination waiver for Tdap during the period when they are offering the annual influenza vaccine.

TMA ~~E~~encourages physicians (and others, including advance practice nurses and midwives) practicing obstetrics quality-of-care measures in private practice ~~(and others, including advance practice nurses and midwives)~~ ~~offer~~ to strongly encourage influenza vaccination ~~to~~ of pregnant women, especially those during the second ~~o~~r third trimester of pregnancy, or upon postpartum hospital discharge. TMA supports ~~offering~~ ensuring that ~~these~~ women ~~the option of~~ receive~~ing~~ the tetanus-diphtheria-pertussis vaccine (Tdap) between 27-36 weeks of each pregnancy, or as recommended by the ACIP. ~~at the time of hospital discharge.~~ ~~as well, preferably as~~ Use of a standard delegated medical order will facilitate administration of Tdap to this population (CM-ID Rep. 2-A-08).

Recommendation: Retain as amended.

REPORT OF COMMITTEE ON REPRODUCTIVE, WOMEN'S, AND PERINATAL HEALTH

CM-RWPH Report 1-A-18

Subject: Evaluation and Management of Stillbirth

Presented by: Shanna Combs, MD, Chair

Referred to: Reference Committee on Science and Public Health

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In its sunset review of TMA Policy 140.009 Perinatal Autopsies Following Stillbirth (fetal death at 20 weeks or greater), the Committee on Reproductive, Women's, and Perinatal Health concluded a singular focus on autopsy, per se, was too narrow to address the greater goal of improving pregnancy outcomes post-stillbirth. The committee believes a broader policy to more comprehensively address evaluation and management of pregnancies complicated by stillbirth would be more appropriate to the goal of improving medical care during the failed pregnancy, as well as positively influencing subsequent interconception care (both physical and emotional for mother and family) and future prenatal care.

There could be major significance to improving stillbirth outcomes, since the U.S. fetal mortality rate slightly exceeds the infant mortality rate. In 2013, 23,595 fetal deaths were reported in the United States (MacDorman and Gregory, 2015). The Centers for Disease Control and Prevention reports the U.S. fetal mortality rate declined from 25 fetal deaths per 1,000 live births in 1942, to 5.96 in 2013 (MacDorman and Gregory, 2015). However, the occurrence of stillbirth appears to have plateaued. With the most recent fetal mortality rate of 5.98 in 2014, it is relatively unchanged since 2006 (Hoyert and Gregory, 2016).

The risk factors and potential causes of a stillbirth vary; however, the fetal mortality rate for non-Hispanic black women is the highest of all groups and more than twice that of non-Hispanic white women and other populations. Thus, race is a significant risk factor. Others include nulliparity, advanced maternal age, and obesity. Maternal health and prenatal records alone are not sufficient to determine cause of death, nor to provide guidance in subsequent pregnancies.

Physicians recognize that every stillbirth presents an opportunity to improve the clinical understanding of this event and the health of the mother and the infant. In 2009, the American College of Obstetricians and Gynecologists (ACOG) issued clinical management guidelines to address all aspects of stillbirth, including procedures for delivery, the examination of the placenta and fetal remains, reporting, and counseling patients.

Stillbirth Autopsies

The perinatal autopsy is one of the most important tests for evaluation of a stillbirth. But despite recommendations for an autopsy, there are several barriers that limit their use (Ernst, 2016). Studies show the level of invasiveness and the procedural understanding of the autopsy adversely influence the decisions of parents faced with a request for permission to perform the procedure (O'Donoghue, 2015; Sebire, 2013). The costs for autopsy, placental histology, and laboratory testing related to stillbirth are not covered by Medicaid, Medicare, or private insurance, placing financial burdens on either families or hospitals. In some areas of the state, there may be a lack of clinical expertise and limited access to pediatric and perinatal pathologists.

The United States has made some limited attempts to address stillbirths. In 2014, Congress passed the Sudden Unexpected Death Data Enhancement and Awareness Act, calling for the federal-level collection of data on stillbirths. Most states, including Texas, require only that stillbirths be reported via a death

certificate. The certificates are filed weeks before autopsy or other test results have been received, and the cause of death, if included, may be incomplete or inaccurate. It is unlikely updated amendments to the cause of death are submitted consistently to the appropriate local or state registrar, given physicians' busy schedules and the lack of requirements or incentives for physicians to provide that information.

Texas requirements for a fetal death record and further examination of the cause of death are limited. Rules for filing a death certificate are in Chapter 193 of the Texas Health and Safety Code and Chapter 181 of the Texas Administrative Code. The Texas Department of State Health Services provides the physician or medical examiner with specific instructions on reporting cause of death, including whether cause of death was determined by the use of an autopsy and/or histological placental examination (*Handbook on Fetal Death Registration*).

Discussion

The surveillance, assessment, and development of prevention strategies for maternal mortality and morbidity are priorities within the United States and Texas. Legislative and public health initiatives underway may provide an opportunity to improve the collection and use of fetal death data to address maternal health risks and improve birth outcomes. Fetal autopsy and less invasive procedures including placental examination and pathology, maternal records review, laboratory studies, and other tests can prove beneficial to clinicians and families for better management of future pregnancies (Page, 2017; Fatima, 2014).

The committee recognizes there are clinical and economic challenges related to the evaluation and management of stillbirth. For example, some studies highlight the clinical value of an autopsy in determining the cause of death, while recent research indicates the rate of unexplained death still may range from 30 to 60 percent when autopsies were performed (Pacheco, 2017; Man, 2016). In some sources, the placental histological examination is noted to be the most useful component of the evaluation. In addition to the clinical decisions, there are other challenges to obtaining and integrating the results into ongoing patient care. These may include difficult discussions with grieving parents; lack of available clinical and pathology expertise; adequate private and public financing of autopsies; and challenges in data reporting on the fetal death certificate.

Current American Medical Association policy on stillbirth calls for promotion of stillbirth awareness and research including standardization of the definition of stillbirth and creation of a national repository for stillbirth data. Clearly, increasing opportunities to determine the causes and contributors to fetal death will enable physicians to improve care and better manage parents at risk of a stillbirth. Thus, the committee recommends promotion of the 2009 ACOG clinical guidelines for the management of stillbirth, which address best practices, with the expectation that TMA will monitor progress and assess barriers to fully implementing comprehensive practice guidelines. These guidelines encourage a targeted approach to evaluation, data collection, and treatment, as well as identify the critical need for psycho-emotional support for the mother and family.

In recognition of the need for appropriate evaluation and management of stillbirth, the committee makes the following recommendations:

Recommendation 1: That the Texas Medical Association promote physician awareness of the comprehensive process for evaluation and management of stillbirth including current clinical management guidelines developed by the American College of Obstetricians and Gynecologists.

Recommendation 2: That the Texas Medical Association work with the relevant state health and human service agencies, public and private insurance organizations, and health care associations to explore opportunities to incorporate fetal death data into quality improvement initiatives addressing maternal and

infant health and explore the costs and benefits associated with the evaluation and management of stillbirths.

Recommendation 3: Deletion of the following TMA Policy 140.009 in favor of the comprehensive recommendations provided within this report:

140.009 Perinatal Autopsies Following Stillbirth: The Texas Medical Association encourages the provision and reporting of results of fetal autopsies following stillbirth (CM-MPH Rep. 5-A-06).

Related TMA Policy:
None

Related AMA Policy:
Stillbirth Awareness H-420.956: Our AMA promotes stillbirth awareness and research by supporting standardization of the definition of stillbirth and creation of a national repository for stillbirth data.

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 301
A-18

Subject: Synthetic Cannabis Educational Resources for Providers

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

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Whereas, Synthetic cannabinoids, also known as “Spice,” “K2,” or “synthetic marijuana,” have negatively affected Texas communities since first introduced to the United States in 2009 and have become a top priority of the attorney general of Texas; and

Whereas, Synthetic cannabinoids are defined by the Texas attorney general as “a mix of plant matter sprayed with chemicals in sometimes dangerously high proportions, falsely marketed as ‘legal highs’ and smoked like marijuana”; and

Whereas, From 2010 to summer 2016, synthetic cannabinoid usage resulted in 3,653 calls to the Texas Poison Center Network, 10 percent of which were for “major” or “life-threatening” conditions, and five cases resulted in death; and

Whereas, K2 intoxications recently have been reported in Austin with 52 cases on Aug. 25, 2016, and two cases on Dec. 17, 2017, as well as a mass overdose in 2016 that occurred in Hermann Park in Houston, and a “massive K2 bust” of 600 pounds found in Houston on April 21, 2017, with many more individual cases and deaths not reported in news media; and

Whereas, In the 2016 Texas School Survey of Drug and Alcohol Use, 4.7 percent of high school students stated they had used synthetic marijuana in the past and 13.7 percent stated synthetic marijuana would be “very or somewhat easy” to obtain; and

Whereas, The U.S. Army Public Health Center sent out a public health alert on Jan. 31, 2018, reporting adverse effects of vape oils possibly containing synthetic cannabinoids as well as other unknown substances; and

Whereas, Synthetic cannabinoids have up to 100 times the potency and twice the duration of natural cannabis and lead to significantly different effects based on the individual and on the formulation used, costing on average $4,494.07 per emergency department visit; and

Whereas, The effects of synthetic cannabinoids are unpredictable and may include hallucinations and psychotic episodes, suicidal thoughts and/or actions, seizures, acute kidney injury, and death; and

Whereas, As part of its 2017 evidenced-based updated Lower-Risk Cannabis Use Guidelines, the *American Journal on Public Health* recommended that individuals “abstain from using synthetic cannabinoids” altogether; and

Whereas, Multiple recent articles have called for further research and greater education of clinicians on surveillance and detection of synthetic cannabinoid use; and

Whereas, There is a known "dearth of literature and much misinformation" on the effects of synthetic cannabinoids; and

Whereas, Texas Medical Association members provided testimony to support the designation of synthetic cannabinoids as controlled substances in 2013 during the debate of Senate Bill 263; and

Whereas, American Medical Association policy states that synthetic cannabinoids should be banned nationally; therefore be it

RESOLVED, That the Texas Medical Association support evidence-based strategies that will help treat synthetic cannabinoid overdose and reduce synthetic cannabinoid use; and be it further

RESOLVED, That TMA support research on the prevalence, effects, and implications of synthetic cannabinoid use; and be it further

RESOLVED, That TMA identify evidence-based educational materials on synthetic cannabinoids for physicians to share with patients.

Related TMA Policy:

95.010 Marijuana: The Texas Medical Association supports: (1) further adequate and well-controlled studies of marijuana and related cannabinoids for potential medical uses, particularly in patients with serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and for the application of such results to the understanding and treatment of disease (Committee on Addictive Diseases, p 115, A-94; reaffirmed CSA Rep. 4-A-04); (2) evidence-based strategies that will help to reduce use by children, adolescents, and pregnant women, and others who are at higher risk of adverse effects; (3) identifying resources for physicians on the research relating to marijuana for medical use and working with specialty societies to guide education and information that should be shared with patients; and (4) affirming the physician's right to discuss with his or her patients any and all possible treatment options related to the patients' health and clinical care, including the use of marijuana, without the threat to physician or patient of regulatory, disciplinary, or criminal sanctions. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product (CSA Rep. 4-A-04; amended CSPH Rep. 2-A-14; amended CSPH Rep. 2-A-15).

95.021 National Drug Policy: The Texas Medical Association endorses the consensus statement of the Physician Leadership on National Drug Policy as a rational approach to influencing national policy on drugs, legal and illegal; promotes medical approaches to substance use disorders by continuing to encourage physician involvement in case identification, diagnostic assessment, clinical therapeutic interventions, medical evaluation and management, and ongoing public health and chronic disease management, as appropriate, for cases of alcohol and other drug addiction of legal and illegal drugs; and opposes the legalization of illicit drugs as contrary to the best interests of public health. TMA Supports an emphasis on public health solutions as opposed to criminal justice solutions for legal and illegal drug abuse. Support for the positions of the Physician Leadership on National Drug Policy ought not be construed as support for such legislation. Alcohol and tobacco should be included and emphasized in any program to reduce drug use in the United States.

Physician Leadership on National Drug Policy Consensus Statement: Addiction to illegal drugs is a major national problem that creates impaired health, harmful behaviors, and major economic and social burdens. Addiction to illegal drugs is a chronic illness. Addiction treatment requires continuity of care, including acute and follow-up care strategies, management of any relapses, and satisfactory outcome measurements.

As physicians, we believe that (1) it is time for a new emphasis in our national drug policy by substantially refocusing our investment in the prevention and treatment of harmful drug use. This requires reallocating resources toward drug treatment and prevention, utilizing criminal justice procedures which are shown to be effective in reducing supply and demand, and reducing the disabling regulation of addiction treatment programs; (2) concerted efforts to eliminate the stigma associated with the diagnosis and treatment of drug problems are essential. Substance abuse should be accorded parity with other chronic, relapsing conditions insofar as access to care, treatment benefits, and clinical outcomes are concerned; (3) physicians and all other health professionals have a major responsibility to train themselves and their students to be clinically competent in this area; (4) community-based health partnerships are essential to solve these problems; and (5) new research opportunities produced by advances in the understanding of the biological and behavioral aspects of drugs and addiction, as well as research on the outcomes of prevention and treatment programs, should be exploited by expanding investments in research and training (CPH Rep. 5-A-00; amended CPH Rep. 3-A-10).

190.023 Policy Principles for Medicaid and CHIP Legislative Initiatives (abbreviated): 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. … (AHCM-MAC Rep. 1-1-04; amended SC-MCU Rep. 1-A-15).

Related AMA Policy:

Cannabis and Cannabinoid Research H-95.952

1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating

specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.
4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.

Cannabis Warnings for Pregnant and Breastfeeding Women H-95.936
Our AMA advocates for regulations requiring point-of-sale warnings and product labeling for cannabis and cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed.

Altered Illicit Substances D-95.997
Our AMA will pursue appropriate revisions of the relevant federal laws and regulations as a means of interdicting the manufacture, distribution or sale of such substances.

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 302
A-18

Subject: Appropriate Physician Oversight of EMS Medical Practices

Introduced by: Travis County Medical Society

Referred to: Reference Committee on Science and Public Health

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Whereas, Emergency medical services (EMS) is recognized by the American Board of Medical Specialties as an independent subspecialty with a recognized, unique knowledge base and procedural skill set that is certifiable by board examination; and

Whereas, Texas recognizes EMS as a physician-led medical practice with delegated practice to certified and credentialed nonphysician EMS providers; and

Whereas, The delegation of practice to nonphysicians requires appropriate oversight to ensure quality of care and the safety of patients cared for within the practice; and

Whereas, Such delegation requires appropriate physician support to ensure the professional development of the workforce; and

Whereas, There is no standard formula to define appropriate physician oversight of an EMS medical practice; and

Whereas, The Office of the Medical Director, City of Austin/Travis County Emergency Medical System, has proposed physician oversight ratios recommended by the Travis County Medical Society's (TCMS's) Emergency Department/EMS Advisory Committee and endorsed by the TCMS Executive Board; and

Whereas, Texas patients who use EMS for their emergency medical care expect seamless, safe, high-quality medical care; and

Whereas, The Texas Medical Association is looked to for leadership and advocacy for the safe and effective practice of medicine; and

Whereas, TMA's goals include improving the health of all Texans and strengthening physicians' leadership role; therefore be it

RESOLVED, That the Texas Medical Association recommend Texas emergency medical services (EMS) systems adopt these physician oversight ratios to support safe oversight of EMS medical practices:

- One full-time equivalent (FTE) physician per 500 basic life-support providers;
- One FTE physician per 300 intermediate life-support providers;
- One FTE physician per 100 advanced life support-providers; and
- Two FTE nonphysician support personnel for each physician to ensure appropriate support for management of the EMS medical practice.

Related TMA Policy: None found
Related AMA Policy: None found.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 303
A-18

Subject: "Bathroom" Bills

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

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Whereas, There have been recent political efforts to restrict the use of public facilities, such as restrooms, by our transgender patients; and

Whereas, There is no apparent credible policy benefit to these political efforts; and

Whereas, Approximately 3 percent of youth identify themselves as transgender; and

Whereas, Transgender people are at increased risk for suicidal behavior; and

Whereas, Transgender people who live in states with discriminatory policies have statistically significant increases in mental health and psychiatric diagnoses; and

Whereas, Prejudice and discrimination affect transgender individuals often in the form of physical or verbal abuse or bullying; and

Whereas, There have been recent calls for physicians to "speak up" when they see politicians vilifying groups such as transgender people; and

Whereas, The American Medical Association House of Delegates already has adopted policy opposing any efforts that would prevent a transgender person from accessing basic human services and public facilities in line with one's gender identity; therefore be it

RESOLVED, That the Texas Medical Association oppose any efforts to prevent a transgender person from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms.

Related TMA Policy: None found

Related AMA Policy:
Access to Basic Human Services for Transgender Individuals H65-964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity.

Sources:
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Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 304
A-18

Subject: Improving the LGBTQI+ Patient Health Care Experience

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

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Whereas, Texas has the second-largest population of transgender residents in the United States, numbering approximately 125,350; and

Whereas, The largest portion of transgender individuals in Texas is in the age group of 18-24, numbering 19,200 people in 2016; and

Whereas, Texas' legal landscape and social climate contribute to an environment in which lesbian, gay, bisexual, transgender, questioning, queer, and intersex (LGBTQI+) people are at risk of experiencing stigma, harassment, and discrimination that can lead to economic instability and poorer health outcomes; and

Whereas, Transgender individuals report high levels of anxiety about receiving health care due to perceived discrimination from the medical field; and

Whereas, Nineteen percent of transgender or gender nonconforming individuals reported being refused medical care "due to their gender identity or expression"; and

Whereas, When ill or wounded, 28 percent of transgender or gender nonconforming individuals postponed seeking care due to fear of discrimination; and

Whereas, Lambda Legal, a major American civil rights organization, reported that nearly 56 percent of lesbian, gay, and bisexual respondents and 70 percent of transgender respondents had experienced at least one instance of discrimination when attempting to access health care; and

Whereas, Forty-one percent of transgender or gender nonconforming individuals reported attempting suicide compared with rates of 1.6 percent in the general population; and

Whereas, LGBTQI+ youth contemplate suicide three times more often than heterosexual youth and are five times more likely to have attempted suicide than heterosexual youth; and

Whereas, The World Psychiatric Association recognizes that efforts to change innate sexual behavior in LGBTQI+ youth are not supported by sound scientific evidence and are potentially harmful and unethical; and

Whereas, The refusal to prescribe preexposure prophylaxis (PrEP) to LGBTQI+ people will contribute to the continued threat that HIV poses to the LGBTQI+ community. Fifty thousand new cases of HIV are diagnosed every year despite PrEP's ability to reduce the risk of transmission by 92 percent; and

Whereas, Transgender individuals have reported that hospital intake forms and intake forms at physicians' offices do not have the appropriate gender identification as an option; and

Whereas, A study of transgender youths seeking mental health care found that many individuals gave up on care due to feelings of discrimination from the intake forms not having the appropriate gender pronouns such as, but not limited to, they/them and zhe/zhem; and

Whereas, Transgender individuals often "scan" hospitals and doctors' offices for signs of inclusivity; and

Whereas, Transgender individuals who perceive an environment as inclusive will share more vital health histories and symptoms, as well as follow up with their treatment; and

Whereas, Signs of inclusivity often start with LGBTQI-friendly terminology like gender-inclusive pronouns; and

Whereas, The population of transgender individuals not receiving proper health care leads to increased health care costs associated with higher incidence of major depressive disorder and binge drinking; and

Whereas, The use of gender-inclusive pronouns has been found to increase transgender health outcomes and lower the financial burden of future health risks; therefore be it

RESOLVED, That the Texas Medical Association advocate for the use of lesbian, gay, bisexual, and transgender (LGBT)-friendly language in medical intake forms like the use of gender-inclusive pronouns such as, but not limited to, they/them and zhe/zhem rather than the standard male/female pronouns; and be it further

RESOLVED, That the Texas Medical Association oppose any law that protects discrimination against patients on the basis of gender, gender identity, or sexual orientation; and be it further

RESOLVED, That the Texas Medical Association work with the Gay and Lesbian Medical Association and other appropriate parties to find ways to improve the LGBT patient experience.

Related TMA Policy:
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.

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.

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; (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; (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) state adoption in statutory form of the "mature minor" doctrine and elimination of other statutory barriers to adolescents accessing health care; (b) 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 referral, skillful and understanding personnel working in a good facility, reasonable cost, and professional follow-up; (c) funding at the state and local levels to be established for student-oriented primary care clinics and/or school-linked comprehensive health care for adolescents; and (e) funding to 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; amended CM-CAH & TF Rep. 4-A-17).

55.058 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 (CM-CAH & TF Rep. 4-A-17).

Related AMA Policy:
Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967.
Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; and (2) will advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health.

National Health Information Technology D-478.995. 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.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

Health Needs of Lesbian, Gay, Bisexual and Transgender Populations H-160.991.
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a

part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

Nondiscriminatory Policy for the Health Care Needs of LGBT Populations D-65.996.
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."

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Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 305
A-18

Subject: Addressing Food Deserts in Texas

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

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Whereas, The U.S. Department of Agriculture (USDA) defines "food deserts" as "parts of the country vapid of fresh fruit, vegetables, and other healthful whole foods, usually found in impoverished areas and largely due to a lack of grocery stores, farmers markets, and healthy food providers"; and

Whereas, "Food swamps" can be defined as areas of high availability of nutrient-poor processed and fast foods, with a comparative lack of access to grocery stores; and

Whereas, A 2017 study in the *International Journal of Environmental Research and Public Health* found the presence of a food swamp is a stronger predictor of obesity in a population than the absence of grocery stores; and

Whereas, Obesity and overweight conditions are an expanding health problem that can bring with them adverse health conditions, increased risk for heart problems, cancers, and diabetes; and

Whereas, The Agriculture Act of 2014 dedicated $125 million towards the building of grocery stores and supermarkets in underserved areas, demonstrating federal commitment to improving access to fruits and vegetables in an effort to address chronic diseases and conditions; and

Whereas, Four bills were introduced during the 2017 Texas legislative session addressing the issue of food deserts: Senate Bill 723 (on community development grocery stores), House Bill 3324 (on establishment of a grocery access investment fund), House Bill 3299 (on a franchise tax credit for entities establishing a grocery store in a food desert), and Senate Bill 700 (on reducing property taxes on land used for sustainable farming); and

Whereas, The Texas Legislature, in the past, has failed to pass similar legislation addressing food deserts; and

Whereas, The Pennsylvania Fresh Food Financing Initiative found that only increasing access to fresh groceries in a food desert is not sufficient and that further intervention is needed to encourage patrons to buy fresh foods and healthier groceries; and

Whereas, Research conducted in Seattle showed that opening a supermarket in a food desert increased access to and use of carbonated beverages and processed foods in a population that was not well educated on the benefits of fresh fruits and vegetables; and

Whereas, Community education programs established in Canada have been shown to increase community members' interest in learning to incorporate fresh groceries in their daily diet; and

Whereas, The USDA's Supplemental Nutrition Assistance Program Education and Evaluation Study found that nutrition education provided to low-income schoolchildren led to healthier behaviors and food choices; therefore be it

RESOLVED, That the Texas Medical Association advocate for increased access to grocery stores and fresh foods for impoverished communities and areas with limited access to healthy foods; and be it further

RESOLVED, That the Texas Medical Association support increased education and promotion of food literacy for individuals living in communities with limited access to healthy foods as a means to enable them to choose and consume healthier foods sustainably.

Related TMA Policy:

165.006 Supplemental Nutrition Assistance Program Reform: The Texas Medical Association advocates for reform of the federal Supplemental Nutrition Assistance Program (SNAP) before its constituent U.S. senators and representatives, as well as through its delegation to the AMA, and support/advocate effective SNAP education programs about nutrition and physical activity to help influence overall positive food selections (CPH Rep. 2-A-10).

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).

Related AMA Policy:

Combating Obesity and Health Disparities H-150.944

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol.

Improvements to Supplemental Nutrition Programs H-150.937
1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.

Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake H-150.929
Our AMA will:
(1) Call for a step-wise, minimum 50% 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) To assist in achieving the Healthy People 2010 goal for sodium consumption, will work with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, and other interested partners to educate consumers about the benefits of long-term, moderate reductions in sodium intake.
(3) Recommend that the FDA consider all options to promote reductions in the sodium content of processed foods.

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 306
A-18

Subject: Addressing HB 3859 – A Misstep in the Protection of Foster Care Children

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

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Whereas, In 2017, the Texas legislature passed House Bill 3859 allowing child welfare service providers, on the basis of religion, to refuse prospective foster families and to deny specific services to foster care children; and

Whereas, HB 3859, Section 45.008(f), prohibits provider discrimination against a patient "on the basis of that person's race, ethnicity, or national origin," but offers no protection from discrimination on the basis of a patient's sex, gender identity, or sexual orientation; and

Whereas, HB 3859, Section 45.004(1), protects a provider that "has declined or will decline to provide, facilitate, or refer a person for child welfare services that conflict with, or under circumstances that conflict with, the provider's sincerely held religious beliefs"; and

Whereas, In 2015, there were 427,901 children in foster care in the United States and 29,990 children in foster care in Texas; and

Whereas, The Texans Care for Children organization opposed HB 3859 on the basis that it places "the religious rights of foster care providers ahead of protecting the best interest of children" and recommended amendments be made to prevent provider discrimination against children; and

Whereas, The National Association of Social Workers, Texas Chapter opposed HB 3859 on the basis that the bill implies the protection of discrimination against children, specifically lesbian, gay, bisexual, and transgender children in the foster care system; and

Whereas, HB 3859, Sec. 45.004(3), protects a provider that "has declined or will decline to provide, facilitate, or refer a person for abortions, contraceptives, or drugs, devices, or services that are potentially abortion-inducing"; and

Whereas, HB 3859, Sec. 45.004(4), protects providers who refuse to "enter into a contract that is inconsistent with or would in any way interfere with or force a provider to surrender the rights as outlined in this contract"; and

Whereas, A significant proportion of young women become pregnant within the first year after being discharged from foster care; and

Whereas, The American Academy of Pediatrics officially recommends that adolescents should have access to education about contraception and to contraceptives themselves to reduce adolescent pregnancy rates; and

Whereas, The steady decline in adolescent birth rates, despite unchanging rates of adolescent sexual activity, has been shown to be due to greater access and use of contraception; and

Whereas, Texas has fifth highest rate of teen pregnancy of any U.S. state; and

Whereas, In Texas, only 19 clinics, localized to the major cities, exist to potentially provide abortions for more than 7 million Texas women of childbearing age; and

Whereas, As more laws have passed restricting access to abortion, an increase in internet searches for self-induced abortions (one of the most easily prevented causes of maternal mortality) has been observed; therefore be it

RESOLVED, That the Texas Medical Association support legislation and other efforts to improve access to health care resources for children in the foster care system; and be it further

RESOLVED, That the Texas Medical Association support legislation that protects of the rights of foster care children to receive evidence-based care; and be it further

RESOLVED, That the Texas Medical Association oppose any legislation that allows for discrimination against adolescent patients seeking contraception.

Related TMA Policy:
10.002 Abortion: The Texas Medical Association recognizes abortion as a legal medical procedure, and the performance of abortion must be based upon early and accurate diagnosis of pregnancy; informed and nonjudgmental counseling; prompt referral to skillful and understanding personnel working in a good facility; reasonable cost; and professional follow up. (Remarks of Speaker, p 12, A-85; reaffirmed: Council on Public Health, p 105, I-89; Res. 28WW, p 218-D, A-92; Res. 28J, p 168, A-94; and Council on Health Facilities, p 64, A-97; reaffirmed CPH Rep. 2-A-07; amended CSPH Rep. 3-A-17).

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.

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.

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; (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; (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) state adoption in statutory form of the "mature minor" doctrine and elimination of other statutory barriers to adolescents accessing health care; (b) 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 referral, skillful and understanding personnel working in a good facility, reasonable cost, and professional follow-up; (c) funding at the state and local levels to be established for student-oriented primary care clinics and/or school-linked comprehensive health care for adolescents; and (e) funding to 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; amended CM-CAH & TF Rep. 4-A-17).

55.033 Children's Mental and Behavioral Health: Texas has a relatively young population, with about 28 percent of Texans under the age of 18. TMA recognizes that many mental health disorders of childhood are the basis of both physical and mental disease throughout an entire lifespan. Childhood and adolescence are critical times for brain development; consequently, many mental disorders develop during these periods.

Managing mental health disorders among children requires multiple strategies.

Physician Education. All physicians should have adequate information that enables them to recognize common mental disorders. Primary care physicians should be provided educational tools regarding the screening, diagnosis, and current available treatment modalities for mental disorders such as attention deficit disorder, mild depression, and mild anxiety. TMA can provide resources for physicians on national screening and treatment guidelines, and billing and coding information.

Practice. Access to care remains a critical issue for children and adolescents with mental health disorders, especially underserved children. A physician-led medical home, therefore, can play an important role in recognizing, consulting, and treating children with mental health disorders by following the United States Preventive Services Task Force (USPSTF) recommendations for screening children and adolescents for mental health disorders.

All physicians who see and treat children should be able to recognize and either treat or refer children with obvious mental illness including substance abuse disorder.

Because school is the "workplace of the child," primary care physicians should have knowledge of the demands and resources of their local school districts.

Advocacy. TMA should facilitate and advocate for:

a. Continuing mental health education programs for physicians and mental health care providers regarding child and adolescent mental health and substance abuse,

b. Medical schools and graduate medical education programs that recognize the role of primary care physicians and provide effective training and research in all aspects of child and adolescent mental health and substance abuse,

c. Continuing dialogue and networking with the public mental health community on these issues,

d. Minimizing youth exposure to advertisements for legal addicting substances,

e. Positive mental health messages that counteract tobacco and alcohol advertisements,

f. Strong children's mental health networks throughout the state,

g. Emphasizing pediatric mental health education for all physicians who see children,

h. Adequate numbers and quality of mental health professionals throughout the state,

i. Coordinating with the educational system for mentally healthy schools, and

j. Public and private payment systems that fully integrate mental health care services into primary patient care and provide appropriate payment for mental health services. (CM-CAH Rep. 1-A-01; substituted CM-CAH Rep. 1-A-11).

55.058 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 (CM-CAH & TF Rep. 4-A-17).

260.075 Preventative Health Care for Texas Women: The Texas Medical Association supports state efforts to ensure access to family planning services and other key preventive health services for all Texas women in need. Services provided through Texas' family planning program should follow the Quality Family Planning Services recommendations from the Centers for Disease Control and Prevention and the U.S. Office of Population Affairs. Preventive health care benefits for women in Texas should include: physical examinations; on-site, same-day access to FDA-approved methods of contraception, including long-acting reversible contraceptives (e.g., IUDs and implants), which are the most effective of all contraceptive methods; provision of all age-appropriate vaccinations; and important screenings

recommended by the U.S. Preventive Services Task Force, including screenings for diabetes, breast and cervical cancer, heart disease, depression, and sexually transmitted infections. TMA will continue to advocate for state initiatives that address coverage gaps among certain populations in Texas and serve as a partner to the state in ensuring effective, efficient, and transparent operation of the states' women's health and family planning programs (CM-MPH Rep. 4-A-06; amended CM-MPH Rep. 2-A-16).

190.033 Enhancing Children's Health Insurance Program Coverage: The Texas Medical Association supports efforts to repeal the provision in Texas law prohibiting Children's Health Insurance Program coverage for contraception used for reproductive health (Res. 414-A-14).

Related AMA Policy:

Addressing Healthcare Needs of Children in Foster Care H-60.190

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Adolescent Sexual Activity H-60.938

Our AMA (a) endorses the joint position "Protecting Adolescents: Ensuring Access to Care and Reporting Sexual Activity and Abuse"; and (b) supports the following principles for consideration in development of public policy: (i) Sexual activity and sexual abuse are not synonymous and that many adolescents have consensual sexual relationships; (ii) It is critical that adolescents who are sexually active receive appropriate confidential health care and screening; (iii) Open and confidential communication between the health professional and adolescent patient, together with careful clinical assessment, can identify the majority of sexual abuse cases; (iv) Physicians and other health care professionals must know their state laws and report cases of sexual abuse to the proper authority in accordance with those laws, after discussion with the adolescent and/or parent as appropriate; (v) Federal and state laws should support physicians and other health care professionals in their role in providing confidential health care to their adolescent patients; and (vi) Federal and state laws should affirm the authority of physicians and other health care professionals to exercise appropriate clinical judgment in reporting cases of sexual activity.

Rights of Minors to Consent for STD/HIV Prevention, Diagnosis and Treatment H-60.958

The AMA urges state and local medical societies to work with their respective health departments and communities to develop and support appropriate legislation to decrease the spread of sexually transmitted diseases (STDs) in minors, specifically by allowing minors to consent for the means of prevention, diagnosis and treatment of STDs, including AIDS.

Uniformity of State Adoption and Child Custody Laws H-60.959

The AMA urges: (1) state medical societies to support the adoption of a Uniform Adoption Act that places the best interest of the child as the most important criteria; (2) the National Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform Adoption Act; and (3) state medical societies to support adoption of child custody statutes that place the "best interest of the child" as the most important criterion determining custody, placement, and adoption of children.

Adolescent Heath H-60.981
It is the policy of the AMA to work with other concerned health, education, and community groups in the promotion of adolescent health to: (1) develop policies that would guarantee access to needed family support services, psychosocial services and medical services; (2) promote the creation of community-based adolescent health councils to coordinate local solutions to local problems; (3) promote the creation of health and social service infrastructures in financially disadvantaged communities, if comprehensive continuing health care providers are not available; and (4) encourage members and medical societies to work with school administrators to facilitate the transformation of schools into health enhancing institutions by implementing comprehensive health education, creating within all schools a designated health coordinator and ensuring that schools maintain a healthy and safe environment.

Access to Basic Human Services for Transgender Individuals H-65.964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity.

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing 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.

Health Care Needs of Lesbian, Gay, Bisexual and Transgender Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ.

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Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 307
A-18

Subject: Restriction of Provisions of HB 2561 to Schedule II Drugs

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Science and Public Health

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Whereas, House Bill 2561, passed by the 85th Texas Legislature, requires prescribers to access the Texas Prescription Monitoring Program (PMP AWARxE) prior to prescribing any opioids, benzodiazepines, barbiturates, or carisoprodol; and

Whereas, Many such drugs are found on Schedule III and IV of the Texas Controlled Substances Act are of minimal or no abuse potential, and are commonly and safely prescribed and used daily by Texas physicians and their patients; therefore be it

RESOLVED, That the Texas Medical Association work to limit enforcement of HB 2561 to only the prescribing of drugs found in Schedule II of the Texas Controlled Substances Act.

Related TMA Policy:
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).

Related AMA Policy:
Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947
Our AMA:
(1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
(2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
(3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
(4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;
(5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;
(6) will conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;
(7) will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP;

(8) will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and
(9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs.

Curtailing Prescription Drug Abuse While Preserving Therapeutic Use - Recommendations for Drug Control Policy H-95.979

Our AMA (1) opposes expansion of multiple-copy prescription programs to additional states or classes of drugs because of their documented ineffectiveness in reducing prescription drug abuse, and their adverse effect on the availability of prescription medications for therapeutic use; (2) supports continued efforts to address the problems of prescription drug diversion and abuse through physician education, research activities, and efforts to assist state medical societies in developing proactive programs; and (3) encourages further research into development of reliable outcome indicators for assessing the effectiveness of measures proposed to reduce prescription drug abuse.

Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 308
A-18

Subject: Texas Prescription Drug Monitoring Program Data Integration Into Electronic Health Record Technology

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

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Whereas, The United States is experiencing an unprecedented drug epidemic, with opioid overdose deaths continuing to rise each year; and

Whereas, In 2016, opioid overdose deaths claimed 42,249 lives nationally, with 40 percent of these deaths involving a prescription opioid; and

Whereas, Opioid overdose deaths were five times higher in 2016 than they were in 1999, and the number of prescription opioids sold to pharmacies, hospitals, and physicians was four times higher in 2010 than in 19991; and

Whereas, Texas experienced a statistically significant increase of 7.4 percent in drug overdose deaths from 2015 to 2016 — from 2,588 to 2,831 deaths — with prescription and illicit opioid overdose deaths as the main drivers; and

Whereas, prescription drug monitoring programs (PDMPs) are state-run electronic databases that monitor the prescribing and dispensing of controlled substances, like prescription opioid pain relievers; and

Whereas, PDMPs allow physicians, other prescribers, and pharmacists to make more informed prescribing and dispensing decisions for patients by helping them identify patient history with controlled substances, such as prescription opioids, and potential instances of “doctor shopping” for the purpose of diversion; and

Whereas, PDMPs are associated with decreases in opioid-related overdose deaths; and

Whereas, The 85th Texas Legislature in House Bill 2561 that mandated all prescribers and pharmacists, starting Sept. 1, 2019, check the Texas Prescription Monitoring Program (PMP) before prescribing or dispensing opioids, benzodiazepines, barbiturates, and carisoprodol; and

Whereas, Such mandates impose disruptions to the workflow of physicians and add interruptions in patient care by, for example, adding repetitive manual log-in responsibilities through a separate online portal; and

Whereas, Repetitive interruptions to the physician workflow can affect the delivery of high-quality patient care by increasing medical errors and adding to physician fatigue; and

Whereas, The Texas Medical Association strongly supports technological solutions to encourage physician participation in the Texas PMP and worked for three legislative sessions to move it from the

Texas Department of Public Safety to the Texas Board of Pharmacy, which revamped it to a more user-friendly and useful clinical tool; and

Whereas, Integration of PDMP data directly into electronic health record (EHR) systems can facilitate efficient use of PDMP data by physicians and other prescribers because it can provide seamless access to prescription information at the point of care, while minimizing patient care disruptions and offsetting administrative burdens, such as those imposed by HB 2561's Texas PMP use mandate; and

Whereas, In 2013, the state of Washington started integrating its PDMP data into the EHR system in emergency department settings, which resulted in a large increase in the use of the state PDMP; and

Whereas, Other states such as Kansas, Indiana, Pennsylvania, and Louisiana recently have announced efforts to integrate their PDMP data into EHR systems to facilitate a more efficient physician workflow; therefore be it

RESOLVED, That the Texas Medical Association advocate for integration of real-time prescription drug monitoring program data into Texas electronic health record systems.

Related TMA Policy:

260.092 Responsible Opioid Prescribing for Pain Management: The Texas Medical Association supports multidimensional strategies to optimize the treatment of pain and works to educate Texas physicians about the latest evidence-based literature on responsible opioid analgesia management with the goal of reducing the risk to patients and enhancing the public safety regarding opioid use, misuse, abuse, diversion, and nontherapeutic prescribing (Res. 313-A-12).

95.040 Addressing Prescription Drug Abuse and Overdose: Following is Texas Medical Association policy on addressing prescription drug abuse and overdose:

1. That TMA collaborate with state and local public health agencies to promote increased public education programming on the misuse of prescribed medications, support community programs such as 'take back' programs, and targeted programs for special populations, particularly women of reproductive age and families with adolescents and teenagers.

2. That TMA endorse the education of health care workers and opioid users about the use of naloxone (and other opioid antagonists) in preventing opioid overdose fatalities.

3. That TMA implement a plan to promote physician awareness and participation in educational programs on pain relief.

4. That TMA support continued expansion of public funding for treatment and recovery support for persons at risk of substance use and misuse, with a priority given to programs for pregnant and postpartum women.

5. That TMA support improved access to substance use treatment, especially through co-location of physical health, mental health, and substance use services and through wider availability of evidence-based medication-assisted treatments.

That TMA advocate for legislation that (1) allows for appropriate storage and for a trained individual, acting under a standing order issued by a physician, to administer an opioid antagonist to prevent deaths from opioid overdose (2) allows first responders, such as police and fire fighters to have access to and

administer an opioid antagonist in the event of an emergency overdose (3) reduces barriers for medical professionals to prescribe and dispense naloxone (or other opioid antagonists) to family members and friends of an identified patient, and for administrators to do so without fear of legal repercussions, as described as Third Party Prescription/Standing Order Distribution.

That TMA support providing legal protection from drug possession charges for persons seeking medical attention after overdose, as described in model 911 Good Samaritan fatal overdose prevention laws (CSPH and TF-BH Joint Rep. 1-A-15).

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).

Related AMA Policy:

Prescription Drug Monitoring to Prevent Abuse of Controlled Substances H-95.947

Our AMA:
(1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
(2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
(3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
(4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;
(5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;
(6) will conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;
(7) will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP;
(8) will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and
(9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs.

Universal Prescriber Access to Prescription Drug Monitoring Programs H-95.927

Our AMA supports legislation and regulatory action that would authorize all prescribers of controlled substances, including residents, to have access to their state prescription drug monitoring program.

Promotion of Better Pain Care D-160.981

1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice

and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic.

2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.

3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages.

4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines.

5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality.

Improvement of Electronic Prescription Software D-120.944
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.

Support for Prescription Drug Monitoring Programs H-95.929
Our AMA will: (1) continue to encourage Congress to assure that the National All Schedules Prescription Electronic Reporting Act (NASPER) and/or similar programs be fully funded to allow state prescription drug monitoring programs (PDMPs) to remain viable and active; and (2) work to assure that interstate operability of PDMPs in a manner that allows data to be easily accessed by physicians and does not place an onerous burden on their practices.

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980
Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 309
A-18

Subject: Implementing Blood Glucose Screening in Texas Schools

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

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Whereas, Thirty-three percent of Texas children aged 10-17 are currently obese or overweight; and

Whereas, There was a 30.5 percent increase in the diagnosis of diabetes mellitus (DM) type 2 in children aged 10-19 from 2001 to 2009 in the United States; and

Whereas, Diabetes remains the sixth leading cause of death in Texas; and

Whereas, Direct and indirect costs of diabetes in Texas exceed $18.5 billion annually; and

Whereas, Among youth aged 10 years or older in the United States, the rate of new cases from 2002 to 2005 was 18.6 per 100,000 each year for type 1 diabetes and 8.5 per 100,000 for type 2 diabetes; and

Whereas, Numerous studies have found a significant decrease in the progression of prediabetes to DM type 2 with lifestyle education and regular health screenings; and

Whereas, DM type 2 in adolescents is one of the fastest-growing forms of diabetes in the nation; and

Whereas, Diabetes screening was added to physical examination requirements as a preventive measure for school districts in Illinois; and

Whereas, The most vulnerable populations in Texas are at a genetic disadvantage and tend to acquire DM type 2 at a much higher rate; and

Whereas, An estimated half-million Texans have undiagnosed diabetes, limiting effective initiation of care and greatly increasing the burden of disease once it is discovered later in the disease course; and

Whereas, The Texas Medical Association supports the creation and implementation of evidence-based public health legislation to strengthen obesity and diabetes prevention and interventions in the state of Texas; therefore be it

RESOLVED, That the Texas Medical Association support the incorporation of blood glucose screening tests into the Texas school systems; and be it further

RESOLVED, That the Texas Medical Association work with the Texas State Board of Education to incorporate blood glucose screening tests into the annual health-related requirements for school.

Related TMA Policy:
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.

Related AMA Policy:
Addressing Obesity D-440.954
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.

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 310
A-18

Subject: Community Health Workers and HPV Vaccination

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

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Whereas, The incidence of cervical cancer among women is higher in South Texas than in the rest of the state; and

Whereas, Cervical cancer is preventable through vaccination; and

Whereas, Approximately 55 percent of Hispanic girls aged 13-17 in Texas initiate human papillomavirus (HPV) vaccination, which is lower than the initiation rates for Hispanic girls in the rest of the country; and

Whereas, While 41.9 percent of Hispanic girls in Texas complete the three-dose series or receive two doses before the age of 15, this completion rate is lower than that of Hispanics in the rest of the country; and

Whereas, The use of community health workers has been shown to increase initiation rates to a greater extent than the use of educational brochures alone; and

Whereas, The use of community health workers has been shown to increase the rate of completion among those in the Hispanic patient population; and

Whereas, Community health workers have been found to be effective, functional members of the health care team when addressing a variety of health issues; and

Whereas, The Healthy People 2020 target is 80-percent completion of the vaccination series; therefore be it

RESOLVED, That the Texas Medical Association, in cooperation with other interested parties, investigate the potential impact of community health workers on initiation and completion rates of human papillomavirus vaccination (HPV) in underserved populations, such as inner-city and rural populations; and be it further

RESOLVED, That the Texas Medical Association urge the Texas Department of State Health Services and/or local bodies governing community health workers to expand the training and role of community health workers in promoting HPV vaccination; and be it further

RESOLVED, That the Texas Medical Association urge counties and communities to address HPV vaccination through more programs carried out by community health workers dedicated to education and navigation of the vaccination process.

Related TMA Policy:
50.008 HPV Vaccination: The Texas Medical Association will (1) promote the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices recommendations on the use of human papillomavirus (HPV) vaccine; (2) provide education and assistance to clinicians on strategies for implementing HPV vaccination in their practice; (3) promote increased clinician and community awareness on HPV, and HPV-associated cancers and diseases and the scientific data supporting vaccine safety and efficacy; and, (4) work with external stakeholders to promote routine vaccination and series completion for all adolescents and young adults (CM-CAH Rep. 1-A-10; amended CM-CAH Rep. 1-A-15).

260.005 Community and Migrant Health Centers: The Texas Medical Association reaffirms the importance of funding for comprehensive primary care, access and public health partnership through community and migrant health center programs (YPS, p 139-140, A-91; amended CPH Rep. 4-A-01; reaffirmed CSPH Rep. 3-A-11).

115.020 Supporting Community-Based Health Care Delivery Models for Vulnerable Patients: The Texas Medical Association supports the concept and implementation of community-based health care delivery models emphasizing meaningful access for vulnerable patients throughout Texas. TMA will collaborate with the county medical societies to advocate before the Texas Health and Human Services Commission, elected officials, and the Centers for Medicare & Medicaid Services for adoption of community-based health care delivery models (Res. 403-A-17).

200.036 Community-Based Medical Education: The Texas Medical Association believes that community-based medical education is a viable model that should be evaluated in each community (BOT Rep. 6-I-00; reaffirmed CME Rep. 2-A-10).

Related AMA Policy:
Incorporating Community Health Workers into the US Health Care System H-440.828:
1. Our AMA encourages states and other appropriate stakeholders to establish that community health workers work under a strict protocol for any activity that relates to clinical matters and that this protocol be developed by the physician-led health care team.
2. Our AMA encourages states and other appropriate stakeholders to conduct background checks on community health workers prior to the community health worker providing services and take the background check results into appropriate consideration.
3. Our AMA encourages states and other appropriate stakeholders to develop a set of defined core competencies and skills of community health workers.
4. Our AMA encourages states to support or establish the training, certification, and continuing education of community health workers that allow for multiple points of entry into the profession.
5. Our AMA encourages health insurers and other appropriate stakeholders to promote sustainable funding mechanisms such as public and private insurance to finance community health worker services and that this funding not be part of funds allocated for physician payment.
6. Our AMA encourages states and other appropriate stakeholders to engage in collaborative efforts with community health workers and their professional organizations in the development and implementation of policies related to community health workers.
7. Our AMA encourages states to consider privacy and liability issues related to the inclusion of community health workers in the physician-led health care team.

Human Papillomavirus (HPV) Inclusion in High School Education Curricula D-170.995:
Our AMA will: (1) strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in both males and females, the causal relationship of HPV to genital

lesions and cervical cancer, and the importance of routine pap smears in the early detection of cervical cancer; and (2) urge that students and parents be educated about HPV and the availability of the HPV vaccine.

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872:
1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.
3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

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Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 311
A-18

Subject: Encouraging Unstructured Playtime in School

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

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Whereas, In 2016, one-third of Texas children aged 10 to 17 were overweight or obese; and

Whereas, Reduced recess or physical activity time correlates with higher rates of childhood obesity in certain ethnic groups; and

Whereas, Decreasing sedentary time and increasing physical activity during the school day can reduce the risk of developing chronic illnesses such as type 2 diabetes mellitus, obesity, cardiovascular disease, osteoporosis, and cancer; and

Whereas, Regular physical activity helps build strong bones and muscles, aids in development of fine motor skills, and promotes healthy lifestyle habits that can last into adulthood; and

Whereas, The Centers for Disease Control and Prevention (CDC) recommends 60 minutes of physical activity per day for children aged 6 to 17; and

Whereas, Only 21.6 percent of U.S. children in this age range meet the recommended 60 minutes of physical activity for at least five days out of the week; and

Whereas, Current Texas statute requires only 30 minutes of moderate or vigorous physical activity daily for children in kindergarten through fifth or sixth grade; and

Whereas, If a school district determines this requirement to be impractical for any grade K-6, then the statute requires at least 135 minutes of moderate or vigorous physical activity per week; and

Whereas, “Physical education” is defined as a class led by a teacher to provide developmentally appropriate, structured activities to comply with the statutory requirement for moderate to vigorous physical activity during the school day; and

Whereas, Although physical education is an important part of a child’s education and physical health, it lacks the cognitive, emotional, and social benefits of unstructured playtime; and

Whereas, Each school district determines its own policy for recess in its schools, leading to inequality in recess time across Texas; and

Whereas, Schools in high-poverty areas are shown to offer comparatively less recess time for their students; and

Whereas, In 2016, some Austin school board members were unaware that recess was not offered at 10 of their 83 school campuses; and

Whereas, Pressure has increased on schools and children to achieve academic success in classes and standardized testing at the cost of sacrificing recess time; and

Whereas, Unstructured play gives children a break from academics, allowing time for cognitive processing of recently learned material; and

Whereas, Studies show that breaks can reduce stress and anxiety and increase productivity and attention in the classroom, and this finding was especially true for children with attention deficit hyperactivity disorder; and

Whereas, An observational study showed that elementary school students were less fidgety and more attentive on days they had recess compared with days with no recess; and

Whereas, Texas Christian University's Let's Inspire Innovation 'N Kids (LiiNK) Project allows kindergarten through second grade children to have four 15-minute recess breaks each day, with four 15-minute character development lessons, and initial program results show a decrease in classroom disruptions, less bullying between peers, and reduced transition time between recess and returning to class; and

Whereas, Peer interaction and imaginative play during unstructured playtime promotes social and emotional learning; and

Whereas, During recess, children learn how to work with each other and develop problem-solving skills, self-discipline, emotional self-regulation, and communication skills; and

Whereas, A 2010 CDC review of 50 studies on recess during the school day found that additional recess time did not have a negative impact on academic performance, classroom behavior, or cognitive skills; and

Whereas, The American Academy of Pediatrics states that "recess is a crucial and necessary component of a child's development and, as such, it should not be withheld for punitive or academic reasons"; therefore be it

RESOLVED, That the Texas Medical Association encourage daily physical activity for children as a means to prevent childhood obesity and promote physical and mental health; and be it further

RESOLVED, That the Texas Medical Association recognize the importance of unstructured playtime in addition to the current physical education requirements to encourage physical, cognitive, and emotional development; and be it further

RESOLVED, That the Texas Medical Association support the development of a recess policy to encourage each school district to have unstructured playtime in addition to physical education at each elementary school campus.

Related TMA Policy:
55.019 School Health Education: The Texas Medical Association encourages physicians to become involved with school health education planning committees in their communities and to promote comprehensive school health education (Committee on School Health and Children with Disabilities, p 96, A-95; reaffirmed CM-CAH Rep. 1-A-06; reaffirmed CM-CAH Rep.1-A-16).

260.093 Clinical Approaches to Obesity Prevention and Treatment: The Texas Medical Association will work to (1) identify current assessment practices of physicians to determine what tools are needed for them to address overweight and obesity in the care of their patients; (2) survey health plans to identify current coverage policies and reimbursement practices; (3) identify tools that health plans are using to assist patients, families, and physicians to better address overweight and obesity; and (4) collaborate with health plans on strategies for payment on obesity prevention and treatment to include conducting a pilot project with one or more health plans which will include payment for evidence-based approaches to assess and treat overweight or obese patients. TMA supports the necessary evaluation and research to optimize prevention, screening, diagnosis, and treatment of obesity in children and adults in the primary care setting and will work to develop the necessary tools and communications to assist physicians on covered preventive services including obesity treatment (CSPH Rep. 4-A-12).

55.002 Comprehensive School Health Education in All School Districts: Comprehensive School Health Education in All School Districts: The Texas Medical Association believes the Texas Education Agency should have statutory authority to require comprehensive school health education in all school districts of the state, and that the process should begin with implementation of the TEA-developed modules on physical education, nutrition, substance use, and sexuality (Council on Public Health, p 104-107, I-90; amended CM-CAH Rep. 2-A-01; reaffirmed CM-CAH Rep. 4-A-10).

Related AMA Policy:

Requirement for Daily Free Play in Schools H-470.961

Our AMA recommends that elementary schools maintain at least thirty minutes of daily free play or physical education that is consistent with CDC guidelines.

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 patients with obesity; (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 patients affected by obesity.

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 312
A-18

Subject: Identification Bracelets for Patients With Hearing Loss

Introduced by: Tarrant County Medical Society

Referred to: Reference Committee on Science and Public Health

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Whereas, Hearing loss is the third most prevalent health problem in older adults, following arthritis and heart disease; and

Whereas, Many individuals, including physicians, nurses, and other medical staff, are not aware of the quality-of-life and communication issues that affect people with hearing loss; and

Whereas, Patients with hearing loss in emergency departments, hospitals, and other medical care settings may encounter obstacles such as a lack of a sign language interpreter or other disease problems that further complicate effective communication; and

Whereas, Patient room cards are insufficient in communicating to physicians, nurses, and other medical staff the needs of patients with hearing loss, especially when they are taken out of the room; and

Whereas, Patients already wear identification bracelets on their wrists to provide information such as their name, birth date, and allergies; and

Whereas, An additional identification bracelet or additional information on the bracelet already provided for patients with hearing loss would not be an expensive addition and would improve the quality of care for the patient; and

Whereas, Hearing loss is a major risk factor for dementia and falls, which may have a tremendous impact on the patient's quality of life as well as medical expenses; and

Whereas, Physicians need to encourage patients to be aware of hearing loss as a condition that needs to be diagnosed and addressed early; therefore be it

RESOLVED, That the Texas Medical Association adopt as policy a recommendation for medical care settings, especially hospitals and emergency departments, to provide identification bracelets on patients with hearing loss indicating their hearing status.

Related TMA Policy:
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).

Related AMA Policy:

Treatment of Persons with Hearing Disorders H-35.967

1. Our AMA believes that physicians should remain the primary entry point for care of patients with hearing impairment and continue to supervise and treat hearing, speech, and equilibratory disorders.

2. Our AMA expressly opposes statements that the practice of audiology includes the diagnosis and treatment of hearing disorders; affirms that it is in the public interest that a medical assessment of any hearing or balance malfunction be made by a physician knowledgeable in diseases of the ear; reasserts that audiologists are individuals who perform non-medical testing, evaluating, counseling, instruction and rehabilitation of individuals whose communication disorders center in whole or in part in hearing function; and affirms its respect for the contribution which audiologists have made and continue to make to patient welfare and quality health care in their assistance in the treatment of hearing disorders.

3. Should there be ambiguities in the statutory language of any state which defines audiology, state, and/or specialty medical societies should take steps to seek a legislative amendment to that statute to secure language that describes appropriately the practice of audiology. Misrepresentation by audiologists of their skills and/or the scope of their practice should be reported to appropriate state authorities.

Early Hearing Detection and Intervention H-245.970

Our AMA: 1) supports early hearing detection and intervention to ensure that every infant receives proper hearing screening, diagnostic evaluation, intervention, and follow-up in a timely manner; and 2) supports federal legislation that provides for the development and monitoring of statewide programs and systems for hearing screening of newborns and infants, prompt evaluation and diagnosis of children referred from screening programs, and appropriate medical, educational, and audiological interventions and follow-up for children identified with hearing loss.

Supplement
Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 313
A-18

Subject: Raising the Minimum Purchase Age for All Guns to 21

Introduced by: Ryan Van Ramshorst, MD, Texas Pediatric Society

Referred to: Reference Committee on Science and Public Health

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Whereas, Gun violence is a public health threat to children; and

Whereas, While mass shootings always command our attention, children remain at risk for suicide, homicide, and unintentional injury from guns every day; and

Whereas, Firearm-related deaths are the third leading cause of death overall among U.S. children aged 1 to 17 years; and

Whereas, The minimum purchase age for handguns is 21; therefore be it

RESOLVED, That the Texas Medical Association support federal and state bills that raise the purchase age for all guns to be in line with the current minimum age for handguns, which is 21 years.

Related TMA Policy:
260.015 Firearms: Firearm use and gun control are highly controversial issues in Texas and the United States. The Texas Medical Association supports (1) the primary prevention of firearm morbidity and mortality through educating Texans about gun safety and responsible gun ownership; (2) the Texas Hunter Education and certification program developed by the Texas Department of Parks and Wildlife; (3) physicians in the clinical setting providing anticipatory guidance on responsible gun use in an informational, nonjudgmental manner, while respecting parental decision-making; (4) strict enforcement of federal and state gun control laws and mandated penalties for crimes committed with a firearm, including illegal possession; and (5) the use of trigger locks and locked gun cabinets to help prevent unintentional discharge (Res. 28S, p 176, A-93; Substitute CPH Rep. 3-A-08).

Related AMA Policy:
Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

Gun Regulation H-145.999
Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Firearm Availability H-145.996
Our AMA: (1) Advocates a waiting period and background check for all firearm purchasers;

(2) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and

(3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

Waiting Periods for Firearm Purchases H-145.991
The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Supplement
Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 314
A-18

Subject: Extreme Risk Protection Orders and Gun Violence

Introduced by: Ryan Van Ramshorst, MD, Texas Pediatric Society

Referred to: Reference Committee on Science and Public Health

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Whereas, Gun violence is a public health threat; and

Whereas, Mental illness, domestic violence, and substance abuse are often factors that increase risk for gun violence; and

Whereas, Texas prohibits firearm possession by domestic violence misdemeanants but does not require securing firearms or ammunition from domestic abusers who have become prohibited from possessing firearms or ammunition under federal or state law; and

Whereas, Extreme risk protection orders provide a mechanism for family, household members, or law enforcement to petition a court to remove guns temporarily from people at proven risk of harming themselves or others; therefore be it

RESOLVED, That the Texas Medical Association advocate for legislation permitting extreme risk protection orders in Texas.

Related TMA Policy:
260.015 Firearms: Firearm use and gun control are highly controversial issues in Texas and the United States. The Texas Medical Association supports (1) the primary prevention of firearm morbidity and mortality through educating Texans about gun safety and responsible gun ownership; (2) the Texas Hunter Education and certification program developed by the Texas Department of Parks and Wildlife; (3) physicians in the clinical setting providing anticipatory guidance on responsible gun use in an informational, nonjudgmental manner, while respecting parental decision-making; (4) strict enforcement of federal and state gun control laws and mandated penalties for crimes committed with a firearm, including illegal possession; and (5) the use of trigger locks and locked gun cabinets to help prevent unintentional discharge (Res. 28S, p 176, A-93; Substitute CPH Rep. 3-A-08).

Related AMA Policy:
Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

Gun Regulation H-145.999
Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Firearm Availability H-145.996
Our AMA: (1) Advocates a waiting period and background check for all firearm purchasers;

(2) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and

(3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

Waiting Periods for Firearm Purchases H-145.991
The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Revised for Supplement
Items in Supplement are in italics.
Distributed at Meeting

AGENDA
REFERENCE COMMITTEE ON SOCIOECONOMICS
Friday, May 18, 2018
JW Marriott San Antonio Hill Country Resort, Level 2, Cibolo Ballroom 7

1. *President's Report 1 – Physician-Led Initiatives to Address Maternal Mortality and Morbidity*

2. Council on Health Service Organizations Report 1 – Policy Review

3. Council on Health Service Organizations Report 2 – Medical Staff Rights and Responsibilities Bill of Rights

4. Council on Health Service Organizations Report 3 – Due Process Rights in Physician Contracts With Hospitals

5. Council on Socioeconomics Report 1 – Policy Review

6. Council on Socioeconomics Report 2 – Geographic Practice Cost Indices Policy

7. *Council on Socioeconomics Report 3 – Transparency and Payments for Prior Authorizations (Resolution 406-A-17)*

8. *Council on Socioeconomics Report 4 – Compensation of Physicians for Authorizations and Preauthorizations (Resolution 408-A-17)*

9. *Council on Socioeconomics Report 5 – Clearer Language Regarding the Physician's Role in Providing Auxiliary Aid for Effective Communication Under Current Federal Laws (Resolution 411-A-17)*

10. *Council on Socioeconomics Report 6 – Medicaid Work Requirements*

11. *Committee on Emergency Medical Services and Trauma Report 2 – Policy Review*

12. *Committee on Medical Home and Primary Care Report 2 – Policy Review*

13. Resolution 401 – Physicians Allowed To Delegate Ability to Enter EHR Data (McLennan County Medical Society)

14. Resolution 402 – Opposition to Medicaid Work Requirements (Ryan Van Ramshorst, MD, Texas Pediatric Society)

15. Resolution 403 – Under-Reporting of Optometric Diabetic Eye Examinations to Treating Physicians (Harris County Medical Society)

16. Resolution 404 – Opposition to Pain Score as Contributor to Hospital Financial Incentives (Medical Student Section)

17. Resolution 405 – Compensation to Physicians for Authorizations and Preauthorizations (Ori Z. Hampel, MD)

18. *Resolution 406 – Supporting the Reclassification of Complex Rehabilitation Technology (Resident and Fellow Section)*

19. Resolution 407 – Medical Necessity Decisions Are the Practice of Medicine (Harris County Medical Society)

20. Resolution 408 – Protecting the Prudent Layperson Standard (Carrie de Moor, MD, Collin-Fannin County Medical Society, Nueces County Medical Society, Heidi Knowles, MD, Texas College of Emergency Physicians)

REPORT OF TMA PRESIDENT

PRES Report 1-A-18

Subject: Physician-Led Initiatives to Address Maternal Mortality and Morbidity

Presented by: Carlos J. Cardenas, MD, President

Referred to: Reference Committee on Socioeconomics

In September 2017, the Texas Medical Association and the Texas Department of State Health Services (DSHS) hosted a Maternal Health Forum. Based on the interest in and need for solutions to issues identified at this forum, TMA President Carlos J. Cardenas, MD, established the TMA Maternal Health Congress to develop and frame TMA's policy and advocacy on maternal health for the 86th legislative session. The congress consisted of members of TMA's Council on Science and Public Health, Council on Legislation, and Select Committee on Medicaid, CHIP, and the Uninsured, along with numerous statewide physician experts representing multiple specialties.

On March 24, 2018, the TMA Maternal Health Congress began with 2.75 hours of continuing medical education (CME) programming on maternal mortality and morbidity (MMM) in Texas. More than 80 state health care leaders and TMA physician leaders attended the congress. TMA has created a maternal health website with links to videos of each of the CME presentations at www.texmed.org/MHCongress/.

Presenters identified poor access to health care; limited availability of reproductive health services; and benefit limitations of Medicaid, the Children's Health Insurance Program-Perinatal (CHIP-P), Healthy Texas Women (HTW), and the Family Planning Program (FPP) as contributors to Texas having unacceptable levels of MMM. In addition to access barriers, speakers commented on potential inaccuracies in the reporting of maternal mortality in Texas' death registry system and the impact on MMM of chronic underlying health conditions including hypertension, obesity, diabetes, and substance use among women of reproductive age.

David Lakey, MD, chief medical officer of the UT System and chair of the TMA Council on Science and Public Health, led a panel discussion to consider 36 physician and health leader proposals for improving MMM rates that were submitted in response to TMA's request. The majority of proposals addressed factors identified as barriers to care for women while other proposals addressed quality improvement initiatives, prevention and treatment of behavioral health disorders, and improvements to state health programs for women of reproductive age. A full description of the proposals is on the maternal health webpage.

Texas Maternal Mortality and Morbidity and Health Coverage

Maternal mortality and maternal morbidity are key reflections of overall women's health and access to timely health services before, during, and after pregnancy. Even with the recent state corrections to inaccuracies in the maternal death data from 2012, Texas' data paints a troubling picture: Texas has a high rate of maternal mortality relative to many states and developed countries. Among African-American women, the data are even more alarming. A July 2016 report from Texas' Maternal Mortality and Morbidity Task Force described the most dramatic increase in MMM occurring among black women, who account for 28.8 percent of maternal deaths but only 11.4 percent of Texas births.

Texas' rate of maternal morbidity — severe complications following birth — also have increased dramatically. Nationally, while 700 to 900 maternal-related deaths occur each year, researchers conservatively estimate another 35,000-45,000 women will suffer from a severe maternal complication.

In Texas, most deaths occurred 42 days or more after delivery, the same timeframe in which low-income women lose pregnancy-related Medicaid or other coverage. Texas still leads the nation in the number of people who lack health insurance.

Many assume Texas Medicaid covers all low-income and poor women. In reality, to qualify for Medicaid, a woman must have limited income ***and*** qualify based on pregnancy, disability, or extremely limited resources. Working-age, healthy adult women who earn more than $250 per month do not qualify. Pregnancy-related Medicaid coverage ends 60 days postpartum regardless of post-delivery complications. As a result, low-income Texas women must maneuver through federal, state, and locally funded health programs. Preventive care — including annual exams and contraception— and basic primary care can be obtained via the state's women's preventive health programs, but access and availability varies considerably across the state. Moreover, the demand for services far exceeds capacity. For women needing specialty care, including treatment for substance use disorders (SUDs), the picture is even more dire. DSHS estimates only 9 percent of all Medicaid enrollees, including pregnant women, with a substance use disorder are able to obtain treatment. In 2015, the agency had funding to provide SUD treatment to fewer than 600 indigent pregnant women despite this being a priority population.

For low-income immigrant women, Medicaid is unavailable, except in emergency situations. If a low-income immigrant woman is pregnant, she can enroll in CHIP-P, which covers limited prenatal visits, delivery, and two postpartum visits. CHIP-P does not cover treatment of acute or chronic conditions unrelated to the delivery, including treatment for asthma, heart disease, and mental health and substance use disorders. CHIP-P covers care to support the fetus and not the mother. For those covered by CHIP-P, there is no automatic enrollment into Medicaid if income status or eligibility changes (for a detailed overview of women's health care programs, go to www.texmed.org/MHCongress/.

Adult women with an income between 100 percent and 400 percent of the federal poverty level qualify for federal subsidies for coverage purchased via the federal health care marketplace, though affordability of policies purchased there is an increasing concern.

Overview of Proposals and Testimony

Members of the Maternal Health Congress received testimony on each of the 36 proposals and organized them into five areas: (1) access to care, (2) behavioral health prevention and treatment, (3) access to long-acting reversible contraceptives, (4) quality improvement initiatives, and (5) public health programming.

(1) Access to care

Half of the 36 proposals urged TMA to ardently pursue reforms that increase health care coverage for women. Nineteen percent of adult Texas women lack health care coverage, three points higher than the overall statewide average. Rates are higher among women of color, low-income women, and immigrants. Uninsured women are less likely to receive preventive primary and specialty care they need to be healthy, foregoing everything from annual well-woman exams and high blood pressure screenings to behavioral health care and prescription medications.

The lack of regular medical care means uninsured (and underinsured) women tend to have poorer health outcomes, which is borne out in Texas by high rates of MMM. Late entry to prenatal care has been independently linked to increased rates of maternal mortality and severe maternal morbidity According to the Maternal Mortality and Morbidity Task Force and DSHS Joint Biennial Report, July 2016, 60 percent of maternal deaths occur between six weeks post-delivery and one year following delivery. One important

barrier for postpartum care to low-income women is lack of Medicaid coverage. Fifty-three percent of Texas births are paid by Medicaid, but Medicaid coverage for these low-income pregnant women ends 60 days postpartum with no exception. When this happens, women no longer have access to comprehensive coverage to manage and treat pregnancy-related complications.

Federal law allows states to extend coverage to no-disabled, working-age adults earning less than 138 percent of poverty ($16,753 per year for an individual; $34,638 for a family of four), with 90 percent of the costs paid by the federal government. The law also gives states some flexibility to customize their programs to meet their own residents' needs, such as tailoring benefits or requiring copayments. The law does not allow states to narrow eligibility to include only certain populations. However, the current administration may be willing to accommodate a request to cover only low-income adult women or other subset populations.

Existing TMA policy 190.032 Medicaid Coverage and Reform, adopted in 2013, supports the use of federal funds to develop a Texas-designed program to provide health insurance to eligible low-income adults with incomes below 138 percent of poverty. To date, 33 states have done so, and several others have submitted proposals to the Centers for Medicare & Medicaid Service for review.

Participants in the congress readily acknowledge that Texas' legislative and budgetary environment in 2019 will make it challenging for TMA to make progress towards implementing existing policy for all low-income adults. But bipartisan support to address Texas' maternal health crisis might be an opportunity to at least improve coverage for women of reproductive age. There was widespread testimony in support of undertaking all available options to substantially reduce rates of MMM. Motherless households can present dire long-term consequences for children, families, and the state's economy. Several testifiers spoke to the detrimental impact of adverse childhood events — such as the loss or disability of a mother — to the long-term health of families and communities.

Extending coverage not only would improve women's health but also is fiscally sound policy because Texas uses general revenue dollars to pay for services that could be covered by federal dollars. As just one example, Texas could mitigate a significant portion of its Child Protective Services (CPS) costs by investing in appropriate substance use disorder treatment for pregnant and postpartum women. Estimates show that two-thirds of CPS interventions stem from SUDs among parents.

TMA will continue to promote legislative private-public solutions to achieve universal health care coverage consistent with existing TMA policy.

(2) Behavioral health

According to the most recent data compiled by the Texas Maternal Mortality and Morbidity Task Force, drug overdoses are the leading cause of maternal death during and after pregnancy, with most deaths occurring after the 60-day postpartum period. In the majority of cases, a combination of drugs was used, though opioids were detected in 58 percent of cases. For women enrolled in Medicaid, substance use disorder treatment is available as well as treatment for co-occurring mental health conditions. Because services are not uniformly available statewide and capacity at existing facilities is limited, few eligible women actually receive the services despite pregnant women being a priority population. When pregnancy-related Medicaid ends, adult enrollees are automatically enrolled in Healthy Texas Women, but HTW covers only basic depression treatment. Specialty care is not covered. Other services like counseling or therapy also are not included under HTW. The Family Planning Program does not provide mental health screening or treatment. Pregnant and postpartum women ineligible for Medicaid do have access to Texas' publicly funded SUD treatment, but there are limitations on what services are available and narrow eligibility criteria.

To prioritize access to SUD treatment for pregnant and postpartum women, reduce maternal mortality and morbidity from SUD, and enhance SUD treatment, testimony emphasized that treatment should cover all pregnant women and postpartum women regardless of their drug of choice or method of use, and include accommodations for mothers and babies to stay together. Addressing diagnosis and treatment of SUD without stigma and with the goal of maintaining the mother-baby dyad is imperative.

Mental health conditions such as maternal depression also affect health outcomes for pregnant and postpartum women. These women may experience a mental health condition alone or in addition to a SUD. Co-occurring disorders require proper diagnosis and treatment. The Texas Maternal Mortality and Morbidity Task Force reports that suicide is one of the top reasons for maternal death after seven days postpartum.

TMA will continue to advocate that pregnant and postpartum women be prioritized for treatment of a substance use disorder. Part of that advocacy effort is to ensure the availability of support services for children, eliminating any possibility that child care is a barrier to the mother's participation in treatment. In addition, TMA will explore and advance opportunities such as Project Echo and others that promote telemedicine and telehealth solutions to increase access to treatment for pregnant and postpartum women with substance use disorders.

TMA will encourage the American College of Obstetricians and Gynecologists (ACOG) to support physician screening of patients by identifying payment codes for screening and providing information on evidence-based approaches developed by the U.S. Substance Abuse and Mental Health Services Administration to identify and support patients with a substance use disorder.

(3) Long-acting reversible contraceptives

In Texas approximately half of pregnancies are unplanned. Increasing women's ability to plan and space their pregnancies leads to lower abortion rates, improved infant and maternal health, educational and economic opportunities for women and their families, and cost savings for the state. Women who plan pregnancies are more likely to get prenatal care early, have healthier pregnancies, and reduce their risk of having babies born too early or too small. Additionally, women whose pregnancies are unintended are more likely to have a short interval between pregnancies —18 months or less — significantly increasing health risks for both women and infants.

Besides the impact to women and families, unintended pregnancies increase Medicaid costs. The Texas Health and Human Services Commission (HHSC) reports that in 2015 Medicaid paid for 52 percent of all births in Texas, at a cost of $3.5 billion per year for pregnancy- and delivery-related services for moms and infants in the first year of life.

Continued reductions in the number of unplanned pregnancies must be a key component of Texas' efforts to improve maternal health. At the congress, physicians urged TMA to undertake advocacy and educational initiatives to increase women's access to long-acting reversible contraceptives (LARCs), such as implants and intrauterine devices, which are 20 times more effective than other methods. While Texas Medicaid, Healthy Texas Women, and the Family Planning Program do cover LARCs as a benefit, physicians testified their usage among women who want LARCs still remains low, despite legislative guidance to HHSC to increase availability through policy and educational initiatives. Many physicians, hospitals, and clinics do not offer same-day availability of LARCs for women because of low payment, logistical hurdles, and insufficient training on how and when to use LARCs.

TMA's policy 260.075 Preventive Health Care for Texas Women promotes availability of long-acting reversible contraceptives to women. TMA will convene an expert panel of physicians, hospital

administrators, nurses, LARC manufacturers, and state agency officials to identify and resolve barriers preventing widespread availability of LARCs to low-income women.

(4) Quality improvement initiatives

Three proposals called for more consistency in implementing guidelines, standardized protocols, evidence, and other proven resources to reduce maternal mortality and morbidity. Several resources and tools were discussed, including ACOG and the national Alliance for Innovation on Maternal Health (AIM) Maternal Safety Bundles; the Association of Women's Health Obstetric and Neonatal Nurses safety bundles; and toolkits developed by the California Maternal Quality Care Collaborative, which provide important patient safety advances for the health of the mother and child.

Congress attendees discussed making use of the AIM bundles voluntary but readily available to hospital medical staff leaders. In particular, several testifiers said the AIM Maternal Safety Bundles for Obstetric Hemorrhage and for Severe Hypertension in Pregnancy should be prioritized. Women with cardiovascular risk in pregnancy and those who develop hypertension and preeclampsia with a targeted follow-up strategy also should be prioritized. There was widespread support for the development and implementation of quality-based initiatives with standardized protocols and best practices to improve prenatal, labor and delivery, and postpartum health outcomes.

(5) Public Health Interventions

Thirteen proposals submitted called for a range of public health activities to prevent or address maternal mortality and morbidity. These proposals addressed physician training and education, public awareness, improving current benefits and resources of state public health programs for women, and identifying chronic conditions associated with MMM.

State and local public health agencies have a key role in monitoring, and assessing public health and an important component of that role is the analysis of maternal health data. Maternal death records and other data must be accurate to enable the state to assess maternal health status and to identify populations at risk. These data are then used to inform the public on how to prevent adverse health events and to develop interventions to improve health status for women of reproductive age.

Discussion supported proposals that called for better surveillance of maternal mortality and improving physician access to the health records of women of reproductive age, especially those at higher risk of poor maternal health outcomes. They noted that physicians often do not have access to the patient's complete social or medical history. Not infrequently, physicians use an electronic health record, but health information exchange systems do not support interoperability, so physicians cannot access all of a woman's health records. Further, the state's limited health coverage prevents or complicates a physician's ability to provide optimal follow-up care. Several testifiers focused on the importance of quality and accuracy of death records. Suggestions for improving the records included partnering with DSHS to train physicians in their use and working with hospitals to ensure death summaries are captured accurately as part of the review of maternal deaths.

A member of the Texas Maternal Mortality and Morbidity Task Force proposed that TMA engage physicians in understanding the implicit racial bias that may influence care provided to some pregnant women, and black women in particular. TMA will work with others to convene a physician focus group to assess physician bias as a strategy to reduce health disparities. National models are not available, and this provides an opportunity for TMA to facilitate Texas' leadership in this area.

There also was testimony in support of TMA's role in promoting public awareness, such as through the Texas Medical Association Foundation providing seed grants to TMA members, residents, and medical students. These grants could support research and quality projects related to maternal mortality and

morbidity; implement best practice guidelines for perinatal and postpartum care; support local awareness activities such as a "march for mothers"; and increase the public's awareness of the importance of early entry into prenatal care, follow-up postpartum care, and the warning signs of postpartum mood disorders.

Physicians spoke in support improving provider networks and quality of current public women's health programs including Healthy Texas Women and the Family Planning Program; supporting payment for screening, brief intervention, and referral to treatment for substance use disorders; and ensuring HTW and FPP provide additional health benefits for women at greater health risk. Offering women who smoke access to counseling and education to support smoking cessation would be an example.

TMA must advocate for the enhancement of the state's public health programs for women of reproductive age and ensure these state programs address the prevention and management of chronic diseases that have an impact on maternal health. This includes a focus on evidence-based disease prevention services such as screening for substance use and smoking cessation programs, as well as appropriate support services such as transportation and support for models of maternal medical homes.

Conclusion

The TMA Maternal Health Congress provided a unique opportunity for TMA members and allied organizations to articulate a compelling case for Texas to invest much-needed resources towards substantially improving the health for women of childbearing age. Texas must do a much better job providing physicians, hospitals, and communities with accurate, timely, and reliable data on women's health — data that can be used to design effective policy and programmatic interventions.

Pregnancy is a brief period in most women's lives. To ensure healthy birth outcomes, Texas women must have access to appropriate preventive, primary, and specialty care across their reproductive lifespans if the state is going to reduce unacceptable levels of maternal mortality and morbidity. As one testifier said, the death — or grievous illness or injury — of any mother is one too many. Let's get to work.

Recommendation 1: That the Texas Medical Association pursue legislation authorizing the Texas Health and Human Services Commission to: (a) submit a federal Medicaid 1115 demonstration waiver requesting approval to design and implement a tailored health benefits program for eligible uninsured women of childbearing age that provides 12 months' continuous coverage for preventive, primary, and specialty care coverage, including behavioral health services, to women before, during and after pregnancy; (b) ensure adolescents aging out of the Children's Health Insurance Program (CHIP) are seamlessly enrolled into Healthy Texas Women; (c) ensure women losing CHIP-Perinatal are seamlessly connected to the Family Planning Program to avoid gaps in preventive health care; and (d) implement initiatives that improve early-entry prenatal care, including a statewide campaign on the importance of prenatal care during the first trimester, expediting Medicaid eligibility and enrollment for pregnant women, promoting use of telemedicine for routine prenatal care, and reforming the Medicaid transportation program to ensure pregnant women with young children can travel with their children to obtain preventive services.

Recommendation 2: That the Texas Medical Association develop a continuing medical education program for physicians that covers: (1) information on publicly funded support services for women with substance use disorders (SUDs); (2) guidelines for the prescribing of opioids and pain management; (3) efforts to better connect SUD treatment physicians and providers with women's health physicians and providers to ensure women undergoing treatment for these disorders are able to obtain preventive health care services, and (4) diagnosis and treatment of behavioral health issues such as anxiety and depression.

Recommendation 3: That the Texas Medical Association develop legislation to: (1) allocate sufficient state resources to resolve red tape and payment barriers preventing widespread adoption of long-acting

reversible contraceptives (LARCs), including ensuring the state pays physicians, hospitals, and clinics their full LARC acquisition costs so women can obtain a LARC according to clinical best practice; (2) ensure availability of LARCs immediately following delivery to women enrolled in the Children's Health Insurance Program (CHIP)-Perinatal; and (3) remove roadblocks preventing teens from simultaneously enrolling in CHIP and Healthy Texas Women to obtain contraceptive services with parental consent.

Recommendation 4: That the Texas Medical Association develop a continuing medical education program, in partnership with the American College of Obstetricians and Gynecologists District XI (Texas Chapter), Texas Association of Obstetricians and Gynecologists, and Texas Academy of Family Physicians, designed to increase patients' and physicians' awareness of long-acting reversible contraceptives as the most effective form of contraception.

Recommendation 5: That the Texas Medical Association develop continuing medical education programs on: (1) quality-based initiatives with standardized protocols and best practices to improve prenatal, labor and delivery and postpartum health outcomes; and (2) implementation of hospital-based quality improvement initiatives that reduce maternal mortality and morbidity, based on best practice and standardized protocols.

Recommendation 6: That the Texas Medical Association introduce legislation to improve the quality of health data records for women of reproductive age to support patient health, the quality of maternal death records, and the exchange of health information for women of reproductive age. The legislation should encompass: (a) support of comprehensive efforts to improve the state's surveillance of maternal mortality and ensuring Texas' maternal death records have accurate information on the factors associated with maternal deaths; (b) mandates to the Texas Department of State Health Services to develop training and educational materials for physicians and other medical certifiers to accurately report maternal deaths; and (c) mandates to electronic health record systems to improve the interoperability of health records, including resolution of barriers that are preventing the exchange of health information critical to providing quality maternal and postpartum care.

Recommendation 7: That the Texas Medical Association develop a public campaign to increase awareness of the importance of early and timely maternal health care and promote existing community-based efforts.

Fiscal Note: $30,000

Sources:

1. Nearly Dying In Childbirth: Why Preventable Complications Are Growing In U.S., National Public Radio, Dec. 22, 2017.
2. Health Insurance Coverage and Health — What the Recent Evidence Tells Us, Benjamin D. Sommers, MD, PhD; Atul A. Gawande, MD, MPH; and Katherine Baicker, PhD, *New England Journal of Medicine*, August 2017.
3. Texas Maternal Mortality and Morbidity Task Force, 2016.
4. Texas HHSC, Medicaid and CHIP: An Overview, February 2017.

REPORT OF COUNCIL ON HEALTH SERVICE ORGANIZATIONS

CHSO Report 1-A-18

Subject: Policy Review

Presented by: James Guo, MD, Chair

Referred to: Reference Committee on Socioeconomics

TMA periodically reviews House of Delegates policies in the association's Policy Compendium for relevance and appropriateness. The recommendations of the Council on Health Service Organizations for retention and amendments of policies are summarized in this report.

The following policies are recommended for retention:

65.006 **Documentation Guidelines for Follow-up Codes:** Duplicate medical record documentation is unnecessary in an admission history and physical examination. Medical decision making should be the only level of documentation required for any subsequent follow-up coding documentation for an admission history and physical examination (Resolution 29FF, p 161J, A-98; reaffirmed CHSO Rep. 1-A-08).

115.008 **Hospitalists and Intensivists:** The Texas Medical Association opposes the mandatory utilization of hospitalists and intensivists in Texas hospitals and recommends that no hospital medical staff bylaws prohibit the patient from choosing to have his or her principal physician provide for continuity and coordination of care (Res. 407-I-98; reaffirmed CHSO Rep. 1-A-08).

130.014 **Length of Stay Discharge Criteria:** The Texas Medical Association supports the focus of the American Medical Association policy on length-of-stay discharge criteria.

TMA defines discharge criteria as organized, evidence-based guidelines that protect patients' interests in the discharge process following the principle that the needs of patients must be matched to settings with the ability to meet those needs. Physicians, specialty societies, insurers, and other involved parties should join in developing, promoting, and using such evidence-based discharge criteria.

TMA endorses the following principles in development of evidence-based discharge criteria. (a) Objective and subjective patient assessments of stability are matched to the ability of the discharge setting to provide care. (b) Patient care and functional status needs are matched with family or caregiver ability and willingness to participate in patient care activities. (c) Needs for medical follow-up are in alignment with the ability and likelihood patients will participate with follow-up.

TMA supports a discharge process which includes (a) planning, (b) teamwork, (c) contingency plans/access to medical care, (d) responsibility/accountability, and (e) communication.

TMA promotes training at all levels of medical education in the use of discharge criteria to assist in planning for patient care. TMA encourages research in clinical outcomes and utilization of resources in different health care settings (Council on Scientific Affairs, p 137, I-96; amended CSA Rep. 4-A-08).

130.015 **Physician Participation in Medical Staff Affairs:** The Texas Medical Association supports the principle that a hospital may not contract to limit physician participation or staff privileges or the participation or the staff privileges of a partner, associate, or employee of the physician at a different hospital or hospital system. TMA stands opposed to placing conditions on medical staff privileges to physician members by limiting their participation in medical staff matters through such conditions and limitations (Substitute Res. 29GG, p 177D, I-97; reaffirmed CHSO Rep. 1-A-08).

Recommendation 1: Retain.

The following policies are recommended for retention as amended.

85.015 **Advance Care Planning:** All payers, ~~especially~~ including ~~government-funded~~ the Medicare and Medicaid systems, should add advance care planning as a quality measure and a reimbursable physician service (CHSO Rep. 2-A-08).

125.005 **Venipuncture as a Qualifying Home Health Benefit:** The Texas Medical Association requests that the ~~voted to ask the~~ Centers for Medicare & Medicaid Services' ~~to assure that a change in policy that states that Medicare patients whose only at home medical need is venipuncture no longer qualify for skilled nursing services provided under~~ Medicare~~'s~~ home health benefit ~~does~~ not restrict access to venipuncture services to homebound patients with complex medical problems. TMA will call on the American Medical Association to assist in identifying other medically necessary exceptions to this venipuncture exclusion (Amended Committee on Aging and Long-Term Care, p 87, A-98; amended CHSO Rep. 1-A-08).

125.006 **Home Health Care as Part of the Health Care Continuum:** Appropriate patient care in the home setting is part of the health care continuum. The Texas Medical Association (1) promotes the integration of home care into the medical delivery system by educating physicians about home care~~,~~ and advocating for the role of medical directors in home care agencies~~, working to refine HCFA Form 485 used to order home care, and addressing utilization management, quality improvement, and peer review issues in home care~~; (2) takes an active role in developing systems of meaningful and efficient communication between home care agencies and physicians; and (3) participates in development of outcome measures for home care (CHSO Rep. 2-I-98; reaffirmed CHSO Rep. 1-A-08).

Recommendation 2: Retain as amended.

REPORT OF COUNCIL ON HEALTH SERVICE ORGANIZATIONS

CHSO Report 2-A-18

Subject: Medical Staff Rights and Responsibilities Bill of Rights

Presented by: James Guo, MD, Chair

Referred to: Reference Committee on Socioeconomics

The Council on Health Service Organizations recognizes each individual physician member of the hospital medical staff has both rights and responsibilities essential for a well-functioning medical staff. These rights and responsibilities dictate that the medical staff and the hospital's governing body work cooperatively to cultivate a culture that ensures patient safety, as well as improves the quality of care of each patient.

At their 2017 Annual Meeting, the American Medical Association House of Delegates adopted "Medical Staff Right and Responsibilities" that reinforce the working relationship between the hospital medical staff and the governing body.

Recommendation: That the Texas Medical Association adopt the following medical staff rights and responsibilities as TMA policy.

TMA recognizes the following fundamental responsibilities of the medical staff:

- The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the hospital's governing body;
- The responsibility to provide leadership and work collaboratively with the hospital's administration and governing body to continuously improve patient care and outcomes;
- The responsibility to participate in the hospital's operational and strategic planning to safeguard the interest of patients, the community, the hospital, and the medical staff and its members;
- The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation;
- The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct; and
- The responsibility to make appropriate recommendations to the hospital's governing body regarding membership, privileging, patient care, and peer review.

TMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:

- The right to be self-governed, which includes but is not limited to (1) initiating, developing, and approving or disapproving of medical staff bylaws, rules, and regulations; (2) selecting and removing medical staff leaders; (3) controlling the use of medical staff funds; (4) being advised by independent legal counsel; and (5) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for nonphysician members;
- The right to advocate for its members and their patients without fear of retaliation by the hospital's administration or governing body;

- The right to be provided with the resources necessary to continuously improve patient care and outcomes;
- The right to be well informed and share in the decisionmaking of the hospital's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments;
- The right to be represented and heard, regardless of the voting rights of the physician as outlined by the medical staff bylaws, at all meetings of the hospital's governing body; and
- The right to engage the hospital's administration and governing body on professional matters involving their own interests.

TMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of contractual or independent status:

- The responsibility to work collaboratively with other members and with the hospital's administration to improve quality and safety;
- The responsibility to provide patient care that meets the professional standards established by the medical staff;
- The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff;
- The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the hospital;
- The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff;
- The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

TMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of contractual or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the hospital:

- The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws, which right may not be waived as a condition of employment or medical staff privileges;
- The right to make treatment decisions, including referrals, based on the best interest of the patient, subject only to review by peers;
- The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the hospital's administration or governing body;
- The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty;
- The right to full due process before the medical staff or hospital takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments;
- The right to immunity from civil damages, injunctive or equitable relief, and criminal liability when participating in good faith peer review activities; and
- The right to be free of "sham peer reviews" and manipulation of medical staff bylaws by hospitals attempting to silence or inhibit the voicing of physician concerns regarding the advocacy of their patients.

Related TMA Policy:
130.004 Organized Medical Staff: The Texas Medical Association supports the concept of an organized medical staff rather than "...an organized professional or medical staff..." as proposed by the Joint Commission on Accreditation of Healthcare Organizations (Hospital Medical Staff Section, p 160, A-92; reaffirmed CHSO Rep. 5-A-02; reaffirmed CHSO Rep. 2-A-12).

130.006 Hospital Medical Staff Bylaws: The Texas Medical Association supports changes in current laws to make established hospital medical staff bylaws binding upon and enforceable by the hospital medical staff and the board.

TMA policy is for Hospital Accrediting Organizations to include in its standards a provision which would require that medical staff bylaws, when formally approved by a hospital governing board, be mutually and equally binding on both the governing board and the medical staff.

TMA endorses the following principles for inclusion in future drafts of the Medical Staff Chapter of the Accreditation Manual for Healthcare Organizations:

(1) Continue the use of the term "medical staff" in the title of the chapter and throughout the manual;
(2) Provide consideration of qualified limited licensed practitioners when authorized by state laws and approved by the executive committee of the medical staff and the governing board;
(3) Require that 100 percent of the voting members of the executive committee be fully licensed physicians actively practicing; and
(4) Ensure that all hospitalized patients receive the same standard of care through appropriate language relating to admissions and the responsibility for the medical care of patients (Hospital Medical Staff Section, p 151-152, A-93; reaffirmed CHSO Rep. 1-A-03; amended CHSO Rep. 1-A-13).

REPORT OF COUNCIL ON HEALTH SERVICE ORGANIZATIONS

CHSO Report 3-A-18

Subject: Due Process Rights in Physician Contracts With Hospitals

Presented by: James Guo, MD, Chair

Referred to: Reference Committee on Socioeconomics

In 2012, the TMA House of Delegates adopted Policy 185.020 Principles for Employment Contracts, as a response to Board of Trustees Report 12-A-11, related to Key Protections of Physician Clinical Autonomy. Despite such policy, physicians continue to be subjected to contracts that do not provide for a fair hearing and review in front of their peers, including when the health facility unilaterally terminates a physician.

The U.S. Health Care Quality Improvement Act of 1986 (HCQIA) applies to all hospitals receiving federal funds and requires that hospital medical staffs grant due process rights to physicians. Additionally, the Joint Commission accreditation standards for hospitals also provide for due process rights in these situations by requiring that a physician have access to a fair hearing and review when the medical staff makes an adverse decision regarding the medical privileges of that physician. Despite HCQIA and Joint Commission requirements to afford physicians who serve on a medical staff due process rights, hospitals continue to have the ability to deny these rights by including provisions in the contract with physicians that allow hospital administrators to terminate a physician with or without cause, without a fair hearing.

Medicare's Conditions of Participation for hospitals have yet to be revised to allow for this due process for physicians. The Conditions of Participation for hospitals, most recently modified in May 2014, do not specifically prohibit hospitals or physician staffing companies from containing clauses in contracts that allow hospital administrators to terminate a physician with or without cause.

After much discussion and debate, the Council on Health Service Organizations recommends that TMA continue to advocate for the rights of the medical staff in hospital settings.

Recommendation 1: That the Texas Medical Association advocate for the Centers for Medicare & Medicaid Services' strengthening of the due process rights of physicians by revising Medicare's Conditions of Participation for hospitals to guarantee that physicians be entitled to fair hearings by peers before any termination or restriction of medical staff privileges and that those due process rights cannot be denied through a third-party contract.

Recommendation 2: That Policy 185.020 Principles for Employment Contracts be amended as follows:

Principles for Employment Contracts: The need to protect quality patient care and the physician's exercise of independent medical judgment in providing that care to patients, both in the context of accountable care organizations and hospital physician employment efforts, is paramount. Principles that physicians may want to consider when independently evaluating contract offers should focus on protecting professional judgment. An employment contract should contain provisions, subject to individual negotiations, that address the following principles.

1. Whistleblower Protection from Retaliation. An employment arrangement with a physician should ensure that the patient's well-being is placed first. Therefore, provisions to guarantee that physicians are

free to make complaints regarding interference in medical decisions by nonphysicians to an appropriate authority without fear of reprisal should be considered for inclusion in employment contracts.

2. Due Process Protections. Physicians must be provided due process in credentialing and privileging, quality assurance activities, utilization review, and peer review. Due Process in terms of TMA activities means, at a minimum, the right to notice, a hearing, and an appeal to a physician board to challenge adverse decisions, including termination from the medical staff. Inclusion of Due Process protections in contracts serve to provide a fair forum for physicians when they advocate for patients (among other things). The physician will continue to work until due process is completed unless the physician poses an imminent threat to patients. If a physician is restricted from clinical work during due process, the physician should be compensated appropriately by the institution if the allegations are not confirmed. Furthermore, due process rights should not be able to be waived by a third-party contract.

3. Medical Staff Bylaws as Contracts. Medical staff bylaws of any entity that may employ physicians (not owned by licensed Texas physicians) should have the legal effect of a contract enforceable by the physicians subject to its terms.

4. Referral Limitations. Physicians employed by nonphysician entities must have the freedom to refer patients based on the physician's clinical judgment and not be directed to refer patients to a favored facility or provider. The contract should reflect that freedom of choice.

5. Prohibitions on "Clean Sweep" Clauses. A physician's privileges to practice within a hospital facility or other affiliated institution must not be contingent upon employment by any particular nonphysician entity. Thus, the termination provisions of the contract of employment must not affect an individual physician's privileges to practice in a facility. Furthermore, hospital bylaws should not make privileges contingent on employment.

6. Fair Dispute Mechanism for Performance Measurements. When a nonphysician entity rates or evaluates a physician's performance through measures or standards, a fair dispute mechanism must exist in the contract to challenge:

a. The physician's involuntary termination;
b. The physician's failure to meet satisfaction of performance standards;
c. The physician's eligibility to receive savings or distributions from the nonphysician entity;
d. The amount of the distribution received by the physician from nonphysician entity;
e. The patients assigned to the physician's care under the nonphysician entity;
f. The measurements used to determine the quality of care/efficiency of care provided to patients under the nonphysician entity; and
g. Any assessment of the quality of care provided to patients by the physician.

7. Freedom of Choice of Liability Coverage. Physicians must have the freedom to choose medical liability coverage from the carrier of their choice, and not be required to purchase such coverage from the hospital's preferred carrier (CHSO Rep. 1-A-12).

Related TMA Policy:
265.001 Exclusive Contracts: Exclusive contracts should never be used to circumvent medical staff bylaws as a mechanism to solve quality assurance problems. In addition, TMA policy provides that members of the medical staff under exclusive contract should be subject to medical peer review, due process, and recredentialing activities identical to those for other medical staff (Amended Res. 28P, p 151, I-91; reaffirmed CHSO Rep. 5-A-02; reaffirmed CHSO Rep. 2-A-12).

130.017 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.

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. 401-A-17 and Res. 406-A-07; reaffirmed CM-PPA Rep. 2-A-17).

REPORT OF COUNCIL ON SOCIOECONOMICS

CSE Report 1-A-18

Subject: Policy Review

Presented by: John T. Carlo, MD, Chair

Referred to: Reference Committee on Socioeconomics

House of Delegates policies in the association's Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the council with recommendations for retention, amendment, and deletion.

The council finds that the following policies remain relevant and appropriate:

65.007 **Evaluation and Management Guidelines:** The Texas Medical Association will collaborate with the Centers for Medicare & Medicaid Services, its contractors, and other stakeholders to ensure that any future modifications of the Evaluation and Management (E&M) Guidelines will provide fair treatment of physicians and their patients. TMA will work with other physician organizations to define what constitutes "appropriate and valid documentation"; oppose unwarranted fraud and abuse penalties due to inadvertent errors in coding and interpretation of the E&M documentation guidelines; use all available means to ensure that the burden of proof for fraud and abuse rests with the government; and with the AMA, identify the negative impact of the documentation guidelines on electronic health records and related software and coding and claims processing software, and strongly oppose the inappropriate use of such software for both Medicare and non-Medicare purposes (Amended Res. 29LL, p 161P, A-98; amended CSE Rep. 1-A-08).

65.008 **Downcoding of Claims:** The Texas Medical Association opposes the practices of unilateral downcoding and bundling by insurance companies and their agents and will take all necessary steps to stop these unreasonable business practices (Amended Res. 404-I-98; reaffirmed CSE Rep. 1-A-08).

110.008 **Health Care Costs as Tax Deductible:** The Texas Medical Association is committed to a national legislative initiative promoting health care costs as a tax deductible item regardless of whether the cost is incurred by an employer or an individual (Amended Res. 29I, p 148, A-98; reaffirmed CSE Rep. 1-A-08).

115.009 **Physician-Owned and -Directed Health Care Delivery Systems:** The Texas Medical Association supports the development of physician-owned and -directed health care delivery systems (Amended Res. 403-I-98; reaffirmed CSE Rep. 1-A-08).

115.013 **Second Surgeons:** The Texas Medical Association recognizes that the services of a second surgeon (assistant surgeon), when requested by the primary surgeon, are medically necessary professional services provided to the patient and are separate from the services of the primary surgeon (Res. 416-A-08).

145.009 **Individual Responsibility for Health Care:** The Texas Medical Association encourages employers, employee groups, and other public policy advocates to work together to design and introduce innovative and cost-effective mechanisms to finance health insurance coverage that could be owned and selected by individuals, flexible for each individual's and family's needs, and available as part of or as an alternative to traditional employer-sponsored health plans. TMA is committed to working with business and government to preserve the private sector and to establish an insurance market that is understandable and affordable, as well as portable for individuals (Amended Res. 29X, p 161B, A-98; reaffirmed CSE Rep. 1-A-08).

145.010 **Standard Information for Insurance ID Cards:** The Texas Medical Association supports a minimum set of informational elements that should be included and kept current on each individual's insurance membership card and will work with the state's insurers, health plans, and the insurance commissioner to establish those elements (Res. 405-I-98; reaffirmed CSE Rep. 1-A-08).

180.008 **Managed Care Capitation:** In managed care plans utilizing the capitation payment methods, physicians and their patients should not be required to make medical care decisions based on cost containment instead of quality of patient care (Res. 28V, p 180, A-94; reaffirmed CSE Rep. 1-A-08).

180.024 **Conflict Between Physician Ethics and Health Plan Business Practices:** The Texas Medical Association continues to support health insurance business practices reforms in the Texas Legislature and continues to advocate for high standards of ethical practice by all physicians. TMA calls upon the Texas Medical Board to continue to study the potential conflicts of ethical and financial interests imposed on physicians as part of health plans' business practices (Res. 29AA, p 168D, A-97; amended CSE Rep. 1-A-08).

190.027 **180-Day Minimum for Billing:** Medicaid should pay physicians appropriately for services as long as the physician bills Medicaid for the services within a minimum of 180 days of date of service (Amended Res. 417-A-08).

190.028 **Medicaid and CHIP Applications:** Medicaid should (1) shorten the time from application for benefits to acceptance into the program for qualified patients, and (2) streamline the process for confirming that a patient does or does not have Medicaid coverage (Res. 422-A-08).

195.028 **Medicare as a Defined Contribution Plan:** The Centers for Medicare & Medicaid Services should transition Medicare from a defined benefit to a defined contribution plan in which physicians determine the value of the service provided in consultation with their patients (Amended 402-A-08).

235.028 **Texas Revised Franchise Tax:** The Texas Medical Association will continue to advocate for proper tax treatment of uncompensated care with the Texas comptroller (CSE Rep. 3-A-08)

245.015 **Physician Joint Negotiation with Health Care Payment Plans:** The Texas Medical Association and the American Medical Association will work diligently with the Federal Trade Commission to provide an exemption to allow physician joint negotiation with health care payment plans (Amended Res. 111-A-08).

260.052 **Preventive Screening Tests:** The Texas Medical Association voted to work vigorously towards repeal of rules which prohibit payment for preventive screening tests, including cholesterol levels and diabetes, among others, and to urge the AMA to lead organized medicine in a vigorous campaign to have these rules repealed (Res. 29S, p 158, A-98; reaffirmed CSE Rep. 1-A-08).

Recommendation 1: Retain.

The council recommends amending these policies as follows:

55.029 **Children's Health Insurance Program:** The following policy principles guide the Texas Medical Association's advocacy on the Children's Health Insurance Program:

(1) CHIP eligibility should be offered to the highest extent allowed by federal law;

(2) CHIP should be administratively simple for patients, physicians, and health care providers;

(3) CHIP should promote parental responsibility for health care services by setting fair but simple cost-sharing arrangements;

(4) Information about CHIP should be readily available to parents, physicians, and other health care providers;

(5) CHIP's benefit package should address the physical and mental health care needs of children~~.~~, including access to all FDA-approved contraceptive medications and devices. Appropriate medical specialists, such as pediatricians and child psychiatrists, should guide the benefit package's design;

(6) CHIP should benefit children with special health care needs;

(7) CHIP participants must have access to physicians and facilities trained in pediatric health care, including pediatric subspecialists and children's hospitals;

(8) Texas should actively explore maintaining ~~using~~ a private sector model for CHIP, ~~including~~ and examine options ~~to~~ allowing families to enroll in existing employer-sponsored health care plans, medical savings accounts, and other private insurance vehicles;

(9) Children enrolled in CHIP should be ~~assured~~ ensured a choice of physicians and health plans;

(10) Plans participating in CHIP should establish appropriate incentives to encourage patients' use of a "medical home";

(11) Texas should simplify Medicaid eligibility standards and enact presumptive eligibility for children in CHIP and traditional Medicaid;

(12) Texas should implement 12-month continuous coverage for children enrolled in CHIP ~~and~~ or traditional Medicaid ~~participants~~;

(13) Mechanisms should be implemented to protect safety-net facilities' patient bases;

(14) Health care professionals participating in CHIP should be ~~assured~~ensured adequate competitive reimbursement;

(15) Texas should allocate dollars to secure federal CHIP funds;

(16) Standards governing health plan access, quality, and financial stability should be applied to participating CHIP health plans;

(17) A state interagency advisory committee should oversee and review CHIP;

(18) Oversight of CHIP should include a clinical advisory committee to advise the state on emerging pediatric services, procedures, and pharmaceuticals, and to recommend changes to the benefit package; and

(19) Texas should establish a mechanism for timely, appropriate, and ongoing provider and public input into CHIP (CSE/CM-CAH Joint Rep 1-I-98; amended CSE Rep 1-A-08).

65.011 **Second Surgeon and ~~Un~~Bundling of Services by Medical Insurers:** The Texas Medical Association recognizes that complex medical procedures require multiple CPT codes for proper coding of the professional services provided and opposes the practice of ~~un~~bundling properly submitted CPT codes listed as a component of complex procedures (Res. 414-A-08).

80.003 **Universal Credentialing Form:** The Texas Medical Association will continue to work with interested stakeholders and the Texas Department of Insurance to ensure that both the electronic and paper versions of the Universal Credentialing Form meet~~s~~ the ongoing needs of physicians participating in health insurance plans without being overly burdensome (Amended Res. 29U, p 160, A-98; amended CSE Rep. 2-A-08).

190.017 **Medicaid Fee Schedule:** The Texas Medical Association ~~voted to~~will work with the ~~Texas Health and Human Services Commission~~ legislature to revise the Medicaid fee schedule to enact competitive payment levels, and ~~to~~ work with the Texas Health and Human Services Commission to ~~seek~~ ensure a systematic administrative method for regularly updating and revising the relative values of the schedule (Council on Socioeconomics, p 121, A-98; amended CSE Rep. 1-A-08).

230.005 **Fee Schedules Mandated by Federal Government:** Amounts listed in fee schedules for medical services mandated by the federal government (e.g., Medicare, Medicaid, and ~~CHAMPUS~~TRICARE fee schedules) are unrelated to "usual and customary," "customary and reasonable," "prevailing," or any other characterization implying a market-based determination (Res. 413-A-08).

265.017 **Pay-for-Performance Principles and Guidelines:** Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the American Medical Association Guidelines for Pay-for-Performance Programs and the following five AMA Principles for Pay-for-Performance Programs:

Ensure quality of care. Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality-of-care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.

Foster the patient-physician relationship. Fair and ethical PFP programs support the patient-physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

Offer voluntary physician participation. Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of nonparticipating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

Use accurate data and fair reporting. Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment, and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

Provide fair and equitable program incentives. Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

Guidelines for Pay-for-Performance Programs

Safe, effective, and affordable health care for all Americans is the American Medical Association's goal for our health care delivery system. AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment AMA's Principles for Pay-for-Performance Programs and provide AMA leaders, staff, and members operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

Evidence-based quality-of-care measures must be the primary measures used in any program.

- All performance measures used in the program must be defined prospectively and developed collaboratively across physician specialties.

- Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.

- All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.

- Performance measures should be scored against both absolute values and relative improvement in those values.

- Performance measures must be subject to the best available risk adjustment for patient demographics, severity of illness, and comorbidities.

- Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.

- Performance measures must be selected for clinical areas that have significant promise for improvement.

Physician adherence to PFP program requirements must conform with improved patient care, quality, and safety.

Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.

PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.

PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.

Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing also should analyze for patient deselection. If implemented, the program must be phased in over an appropriate period of time to enable participation by any willing physician in affected specialties.

Plans that sponsor PFP programs must explain these programs prospectively to the patients and communities covered by them.

Patient-Physician Relationship

Programs must be designed to support the patient-physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.

Programs must not cause conditions that limit access to improved care.

- Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socioeconomic groups, as well as those with specific medical conditions, or the physicians who serve these patients.

- Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

Programs must neither directly nor indirectly encourage patient deselection.

Programs must recognize outcome limitations caused by patient ~~noncompliance~~ nonadherence, and sponsors of PFP programs should attempt to minimize noncompliance through plan design.

Physician Participation

Physician participation in any PFP program must be completely voluntary.

Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.

Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.

Programs should be available to any physicians and specialties wishing to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.

Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).

- Programs should provide physicians tools to facilitate participation.

- Programs should be designed to minimize financial and technological barriers to physician participation.

Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.

Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.

Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.

Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting
Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act ~~(HIPAA)~~.

The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not cause financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a nonpunitive manner.

- Programs should use accurate administrative data and data abstracted from medical records.

- Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.

- Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.

Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.

Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.

Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards
Programs must be based on rewards and not on penalties.

Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.

Programs must offer financial support to physician practices that implement IT systems or software that interacts with aspects of the PFP program.

Programs must finance bonus payments based on specified performance measures with supplemental funds.

Programs must reward all physicians who actively participate in the program and who achieve prespecified absolute program goals or demonstrate prespecified relative improvement toward program goals.

Programs must not reward physicians based on ranking compared with other physicians in the program.

Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.

Programs must not ~~financially~~ penalize physicians financially based on factors outside of the physician's control.

Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

Programs must not penalize physicians financially when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

TMA opposes private payer, congressional, or Centers for Medicare & Medicaid Services pay-for-performance initiatives if they do not meet the AMA's Principles and Guidelines for Pay for Performance (BOT Rep. 14-A-08).

320.007 **Town Gown Medical School Funding**: The Texas Medical Association supports the use of state appropriations to medical schools and graduate medical education (GME) programs for their education, work force, and research missions. However, TMA believes that medical schools should refrain from income-generating activities and services that would result in the generation of funds in excess of those needed to support their education, patient care, and research missions, and that Texas medical schools should refrain from using their state agency/nonprofit status tax exemptions in advertising and promoting their medical services. TMA strongly supports ~~all health plan organizations that receive managed~~ requiring Medicaid ~~contracts~~ managed care organizations to include any ~~including~~ GME training programs located ~~with~~in their geographic coverage areas ~~in~~ among their network(s) of providers serving Medicaid enrollees (Board of Trustees, p 18, I-96; amended CSE Rep. 1-A-08).

335.007 **Workers' Compensation System Audits**: Texas Department of Insurance Division of Workers' Compensation (DWC) should ~~establish~~ maintain clearly written policies related to DWC audits that allow for adequate physician notice and do not cause an undue burden on physician practices. TMA will work with DWC to educate physicians about administrative

due process for audits and specific standards that should be met to reduce the risk of a DWC audit. ~~Because audits are an administrative cost of the workers' compensation system, the Texas Medical Association will seek, through regulation and legislative action, to end the practice of charging the costs of DWC audits to physicians~~ (Amended Res. 29OO, p 161S, A-98; amended CSE Rep. 1-A-08).

Recommendation 2: Retain as amended.

The council recommends deletion of the following policies, as they are no longer relevant:

105.015 **Medical Record Privacy Act:** The Texas Medical Association, through its Council on Legislation, will call upon the State of Texas, acting through its duly constituted legislature, at its next regular session, to enact a Medical Record Privacy Act requiring that the electronic transmission of medical records be secure from interception, reading, and use by any person, organization, institute, or agency not authorized by the person whose medical records are being transmitted (any unauthorized interception, reading, or use by an unauthorized person, organization, institute or agency shall constitute a Class A felony punishable by imprisonment and/or fine); and that the Medical Record Privacy Act encourage adoption of software encryption methods used to secure the electronic transmission and storage of medical records to ensure the privacy of medical records (to ensure that information transmitted to non-U.S. physicians remain confidential, the encryption used should be available worldwide) (Res. 29EE, p 177B, I-97; amended CSE Rep. 1-A-08).

190.026 **Medicaid Preferred Drug List:** The Texas Medical Association will pursue changes in the Medicaid PDL so that Medicaid enrollees can readily obtain medications. Such changes include, but are not limited to, the following:

Change policy on premium preferred generics (PPG) so that the PPG medications do not require prior approval when the pharmacy chooses a non PPG manufacturer.

Eliminate prior approval requirement for drugs that are the only drugs in their class for a specific age group. For example, with nebulized budesonide respules, or Pulmicort, the date of birth can be matched with the medication, and an automatic approval can be generated. Include all forms of a drug in the same PDL category (i.e., if a drug is preferred, then all forms of the drug are preferred - liquid, tablet, capsule, redi-tab, all strengths, and all combinations are included).

List drugs in multiple, searchable, downloadable formats (e.g., alphabetical and by drug class).

Allow exceptions to the rebate requirement in special, carefully defined circumstances.

Allow other modalities for prior approval, including but not limited to, electronic or fax (Amended CM-CAH Rep. 1-A-08).

Recommendation 3: Delete.

REPORT OF COUNCIL ON SOCIOECONOMICS

CSE Report 2-A-18

Subject: Geographic Practice Cost Indices Policy

Presented by: John T. Carlo, MD, Chair

Referred to: Reference Committee on Socioeconomics

Medicare fees are calculated based on three relative values assigned to every procedure: work, practice expense, and malpractice. Each relative value unit is adjusted individually to factor in cost differences based on local economic conditions. The adjustment factors, called geographic practice cost indices (GPCIs), are revised on a five-year alternating schedule based on newer available data. Although Medicare continues to use proxy data that may not always be accurate measures of locality differences in practice cost, it has made multiple improvements in its GPCI measures and calculations.

The biggest current issue with the geographic adjustments is not the GPCI values per se, but the definition of the geographic locality boundaries. Prior to 1996, Texas had 31 localities with their own geographic adjusters. Based on the best data available at the time, the 31 were reduced to eight: seven higher-cost, mostly urban county areas and a single "Rest of Texas" payment area consolidating the remaining counties. Many smaller states were consolidated into single, statewide payment areas. These changes were accomplished through federal rulemaking as part of the general responsibility of the Centers for Medicare & Medicaid Services (CMS) to ensure that geographic adjustments are fair and reasonable. Since the 1996 rule revision, local economic conditions in many Texas counties have changed dramatically due to rapid urbanization, local population changes, and other factors, but CMS has refused to do further locality revisions. Multiple studies of Medicare geographic adjustment by the U.S. Government Accountability Office, the Institute of Medicine, and others have confirmed that many geographic areas in Texas and in other multilocality states are currently being under- or over-paid because of a need to revise locality boundaries and definitions.

Proposed 2007 federal legislation to force an update and provide funding for a hold-harmless provision failed to secure a vote in the U.S. Senate. In 2014, as part of the Protecting Access to Medicare Act, Congress mandated a locality revision solely for California, for phase-in beginning in 2017. CMS currently has no active plan to fix the locality definitions for any other state.

The Council on Socioeconomics reviewed TMA's existing policy on geographic practice cost indices and found it to be outdated. The following proposal represents a complete update of this policy for inclusion in the TMA Policy Compendium.

Recommendation: Amendment of TMA Policy 240.014 Geographic Practice Cost Indices, as follows:

Geographic Practice Cost Indices <u>(GPCIs)</u>: <u>The Texas Medical Association supports geographic adjustments for Medicare payment that are fair and accurate based on variations in local economic conditions. To ensure accurate adjustments, the Centers for Medicare & Medicaid Services (1) should find and apply the most accurate and current available data for use in GPCI calculations, including better data on commercial office costs, current information on medical liability costs, and data to accurately measure the existing variations in costs of medical supplies; and (2) update at least every five years all factors including locality definitions and boundaries. Since locality boundaries for most multilocality states have not been updated since 1996, Congress should mandate an immediate revision using new</u>

boundaries based on metropolitan statistical areas or comparable economic groupings and provide federal funding for hold-harmless provisions to prevent cuts to localities that could be affected adversely.

~~The Texas Medical Association supports efforts to repair methodological flaws in the current calculation of the work and practice expense GPCIs that may be understating the costs to rural physicians. TMA advocates for: (1) eliminating geographic adjustment of the work component of Medicare payment, while retaining and improving the adjustments for practice expense and malpractice, or, at a minimum, revising the calculation of the physician work GPCI to use salary data only for professionals holding advanced degrees, including physicians; (2) recalculating the practice expense GPCIs to make proper allowance for physician's employment of administrative and managerial staff; (3) reevaluating existing databases to find or develop a nationwide measure of commercial office rents for use in calculating practice expense GPCIs; and (4) finding or developing an index that will accurately measure the existing variations in costs of medical supplies~~ (BOT Rep. 39-I-98; reaffirmed CSE Rep. 1-A-08).

Supplement

REPORT OF COUNCIL ON SOCIOECONOMICS

CSE Report 3-A-18

Subject: Transparency and Payments for Prior Authorizations (Resolution 406-A-17)

Presented by: John T. Carlo, MD, Chair

Referred: Reference Committee on Socioeconomics

Background

In May 2017, the TMA House of Delegates referred Resolution 406, Transparency and Payments for Prior Authorizations, to the Council on Socioeconomics.

The resolution as proposed requires the Council on Socioeconomics to review the following:

- Amending TMA Policy 235.034, Authorizations Initiated by Third-Party Payers;
- Allowing physicians to charge subscribers if payers and third parties do not compensate physicians for the prior authorization burdens since these burdens are not a covered service;
- Allowing prior authorizations for only new medications and not for medications that patients have been receiving previously and continuously;
- Pursuing new Texas laws that incorporate the American Medical Association's Ensuring Transparency in Prior 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;
- Supporting legislation to mandate that payers accept and respond to standard electronic prior authorization (ePA) transactions, such as the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard ePA transactions; and
- Asking the Texas Delegation to the AMA to take this resolution to the AMA for a national unified movement.

Managed care contracts between a payer and a physician contain specific information covering the obligations and duties to which a physician has agreed. Some obligations may be clearly defined, such as the promise to provide medical services to patients in exchange for listings in provider manuals and payment. Others may require further investigation by the physician, such as not being allowed to charge for services considered integral to or a component of other services provided. The policies and procedures included in managed care contracts encompass a wide range of topics, all of which affect the physician's practice. There may be policies and procedures specifying which services are covered, how the managed care organization will pay for those services, and how the physician can bill the plan enrollee. Some managed care contracts prohibit the physician from charging both the payer and the patient for the administrative costs associated with obtaining prior authorization approval. If the patient is out-of-network, then the physician has no contractual relationship with the plan.

Shifting the costs associated with prior authorizations to patients could disrupt the patient-physician relationship. If patients are unwilling or unable to pay the physician for prior authorization administrative costs, they could elect to forgo necessary medical care.

The 85th Texas Legislature in Regular Session passed S.B. 680 last year, providing a more standardized process for physician exception requests to step therapy drug protocols. Prior to this new law, the only real protection related to step therapy protocols was a prohibition on health plans adding a step therapy protocol mid-plan year.

Under current Texas law there already exist notice and disclosure requirements of certain information such as health benefit plan prescription drug formularies and step therapy protocols.

In January 2017, the American Medical Association and a coalition of 16 other organizations representing patients, physicians, medical groups, hospitals, and pharmacists released a set of 21 principles related to prior authorization and utilization management reform. The principles cover clinical validity, continuity of care, transparency and fairness, timely access and administrative efficiency, and alternatives and exemptions. They provide a roadmap to guide long-overdue reform of utilization management requirements like prior-authorization and step-therapy requirements. Although TMA was not part of the initial coalition developing the 21 principles, the Association did sign-on in support of the principles.

Electronic Prior Authorization (ePA) is the transmission of information requesting coverage of a specific medication for a specific patient via fax, telephone or web portals between a physician and a claims payer. The standardization of electronic prior authorization is a process integrated into a physician's electronic health record (EHR) and used for medications. Advantages to ePA include workflow efficiencies, standardization, and faster access to medications by patients. Not only do EHR vendors need to be equipped to offer ePA but also health plans and benefit managers must be able to support it. Some companies already offer ePA technology at no cost, and advocacy to make ePA free for physicians is ongoing.

At the 2016 AMA Annual Meeting, the House of Delegates adopted Council on Medical Service Report 7-A-16 Prior Authorization Simplification and Standardization. In addition, the AMA Board of Trustees asked the Council on Medical Service to provide a report on this topic at the 2017 AMA Annual Meeting. The final adopted recommendations in the 2017 AMA report address and support the concerns outlined in TMA Resolution 406. Members of the Texas Delegation to the AMA were instrumental in the development of the 2017 adopted recommendations.

Summary

The overwhelming number of medical services requiring prior authorization has created not only an administrative burden on physician practices but also potential barriers to patients getting medically necessary tests and treatment. The time-consuming processes and associated costs with prior authorization are diverting valuable resources away from direct patient care. Requiring health plans, third-party payers, benefit managers, and utilization review entities to disclose their statistics regarding prior authorization approvals and denials will help educate patients on why medically necessary care ordered by their physician cannot always be delivered in a timely manner.

Recommendation 1: The council recommends that TMA policy 235.034 be amended as follows:

235.034 **Authorizations Initiated by Third-Party Payers<u>, Benefit Managers, and Utilization Review Entities</u>**: The Texas Medical Association supports policy <u>and legislation</u> that <u>(1)</u> third-party payers<u>, benefit managers, and utilization review entities</u> 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<u>; (2) third-party payers, benefit managers, and utilization review entities should disclose all prior authorization requirements</u>

and restrictions on their websites in both the subscriber section and the physician section with neither location requiring a log-in or password; (3) third-party payers, benefit managers and utilization review entities should confirm patient eligibility, payment determinations, medical policies and subscriber specific exclusions as part of the prior authorization process; and (4) third-party payers, benefit managers, and utilization review entities should make detailed statistics regarding prior authorization approval and denial rates available on their website (Res. 401-A-11).

Recommendation 2: The council recommends adopting new TMA policy on standardized electronic prior authorization transactions:

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

Recommendation 3: That Council on Socioeconomics Report 3-A-18 be adopted in lieu of Resolution 406-A-17.

Related TMA Policy:
120.003 Health System Reform Managed Care: To provide a basic framework for association policies and activities in health system reform, the Texas Medical Association: ... (4) supports genuine relief from red-tape hassles and excessive administrative costs of health care; … (7) supports the right of a physician organization to negotiate at the federal or state level for payment of physician services, quality and utilization review, professional liability reform, and to reduce the hassle and cost of regulation; … (Second Supplemental BOT, p 36P-36S, A-93; amended CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13).

180.031 Pharmacy Benefit Managers: The Texas Medical Association will (1) gather evidence of the administrative burden placed on physicians and patients by the policies and operating practices of Pharmacy Benefit Managers (PBMs) in order to document the impact on medical practices and determine whether the business practices of PBMs comply with state laws and regulations; (2) explore the possibility of legislative action should no state laws or regulations apply to the preauthorization process required by PBMs; and (3) promote cooperation by Texas pharmacists to provide physicians with up-to-date information about prescriptive drugs covered by pharmacy benefit managers and appropriate alternative medications in pharmacy benefit managers' formularies (Amended Res. 401-A-06; reaffirmed CSE Rep. 6-A-16).

160.017 Utilization Review: The Texas Medical Association will pursue legislation to ensure that adverse utilization review determinations be made only by physicians who are fully licensed by the Texas Medical Board and monitor proposed legislation to maintain the Texas Medical Board's current authority to enforce the Medical Practice Act in regard to utilization review decisions (CL/CSE Rep. 2-A-09).

145.024 Medical Decision Makers Licensed in Texas: The Texas Medical Association will (1) support legislation that would amend the Texas Insurance Code to require utilization review agents to be supervised by physicians licensed to practice medicine in the State of Texas and all denials of care based on medical necessity to be made by physicians licensed to practice medicine in the State of Texas and in the same or similar specialty as the treating physician seeking authorization of medical care; and (2) work

to amend the Medical Practice Act to clearly include the supervision of persons performing pre-certification or preauthorization based on medical necessity as the practice of medicine; and include any denial of pre-certification or pre-authorization of medical services based on a determination of medical necessity as the practice of medicine (Amended CL Rep. 1-A-08; amended CSE Rep. 5-A-16).

REPORT OF COUNCIL ON SOCIOECONOMICS

CSE Report 4-A-18

Subject: Compensation of Physicians for Authorizations and Preauthorizations (Resolution 408-A-17)

Presented by: John T. Carlo, MD, Chair

Referred to: Reference Committee on Socioeconomics

The 2017 House of Delegates referred Resolution 408 to the Council on Socioeconomics for study and report back at TexMed 2018. The resolution requested the following:

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

The requests contained in the resolution would require rewriting existing federal and state laws that address:

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

There also are concerns about the significant state and federal legislative changes required to implement this resolution. Additionally, legislative activity required to modify existing Texas prompt payment law would open up the possibility of changes to other parts of the law currently favorable to physicians.

Current Procedural Terminology (CPT) is a standardized code set used to report medical procedures and services performed by physicians. The code set is used by entities such as health insurance companies, government payers, and accreditation organizations. All electronic financial and administrative transactions require the use of CPT codes. Physicians who refrain from submitting electronic claims are not required to use any of the standardized code sets. Physicians who elect to establish a cash-only-based

practice are not contracted with any health plans and/or networks. They also do not need to use CPT codes because they do not submit claims to health plans and/or networks. With the movement toward bundled payment methodology, physicians may contract directly with health plans for payment. The services included in those bundled payments cannot be defined by one single code set. The physician may agree contractually to an arrangement that requires data reporting outside the scope of the established code sets and therefore would not be subject to The Health Insurance Portability and Accountability Act of 1996 (HIPAA) reporting requirements.

The use of CPT as a tool to calculate the billable minutes is a modification of CPT. As such it would require review by the American Medical Association, which holds copyright in CPT, and use or reprinting of CPT in any product or publication requires a license.

Existing TMA policy on authorizations initiated by third-party payers, policy 235.034 says, "The TMA 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."

Recommendation: That Resolution 408-A-17 not be adopted.

Supplement

REPORT OF COUNCIL ON SOCIOECONOMICS

CSE Report 5-A-18

Subject: Clearer Language Regarding the Physician's Role in Providing Auxiliary Aid for Effective Communication Under Current Federal Laws (Resolution 411-A-17)

Presented by: John T. Carlo, MD, Chair

Referred to: Reference Committee on Socioeconomics

Background

In May 2017, the TMA House of Delegates referred Resolution 411, Clearer Language Regarding the Physician's Role in Providing Auxiliary Aid for Effective Communication Under Current Federal Laws to the Council on Socioeconomics (CSE). The resolution requested that:

- TMA advocate with interested parties to support clarification of current federal laws in regards to what constitutes effective communication towards patients with interpretative needs;
- TMA support the creation of clearer guidelines with the Americans With Disabilities Act (ADA) for what is considered undue burden and recognize that negative resolution flow be a consideration;
- TMA support measures to provide smaller practices that have limited resources and availability of interpretive services with better legal protections and accessibility to qualified medial interpreters; and
- The Texas Delegation to the American Medical Association bring this resolution to the AMA House of Delegates.

Interpreters for Hearing-Impaired Patients

In 2013, the house asked CSE to review the issue of insurance coverage for the cost of interpreters for hearing-impaired patients. The Americans With Disabilities Act of 1992 (ADA) prohibits discrimination against people based upon their disability or perceived disability, or for advocating for a person with a disability. This includes charging the patient for the cost of a qualified interpreter, if necessary.

Currently, only Texas Medicaid pays physicians for the cost of a qualified interpreter and only in limited situations. It is important to note that under Title III of the ADA, physicians, not the hearing impaired person, choose the interpreter, if one is necessary. A physician "need not accept and pay for the services of a sign-language interpreter who is unilaterally retained by the family of a deaf patient, when the doctor has had no opportunity to make his own arrangements."

Existing TMA policy 90.002 American with Disabilities states: The Texas Medical Association supports seeking a change in the American Disabilities Act to permit public sector funding of interpretation services for the deaf (Res. 28R, p195, I-93; reaffirmed CM-R Rep. 3-A-03; reaffirmed CSE Rep. 2-A-14).

Limited English Proficiency (LEP) Background

A LEP person is an individual "whose primary language for communication is not English and who has a limited ability to read, write, speak, or understand English." The prohibition of discrimination against LEP persons began with the Civil Rights Act of 1964. Since then the issue has been reviewed by the Supreme Court and has been a subject of multiple executive orders. Section 1557 of the Affordable Care Act (ACA) prohibits certain entities that administer "health programs and activities" from discriminating

again individuals based on race, color, national origin, sex, or disability. Although Section 1557 does not mention discrimination again individuals based on language, the rules follow a long-established precedent interpreting a prohibition on national origin discrimination to require entities to take reasonable steps to provide meaningful access to individuals with LEP.

The U.S. Department of Health and Human Services (HHS) issued final rules implementing Section 1557 on May 18, 2016. The rules, found in Title 45 Code of Federal Regulations Part 92, lay out an important compliance framework for physicians and health care providers regarding all types of discrimination, including discrimination against LEP persons. This framework includes factors to help entities determine the reasonable steps they must take to provide meaningful access to LEP person, required notices entities must make available, and assurances that entities must make when applying for federal financial assistance. Most physicians will find themselves subject to Section 1557, which means a physician is obligated to take reasonable steps to provide meaningful access to services and programs to eligible LEP persons. Enforcement of Section 1557 rules include informal means such as "requiring covered entities to keep records and submit compliance reports to the Office of Civil Rights, conducting compliance reviews, and complaint investigation, and providing technical assistance and guidance." If informal means of enforcing the ADA provisions do not bring about compliance, HHS is authorized to enforce compliance by "suspension of, termination of, or refusal to grant or continue Federal assistance, or by referral to the Department of Justice with a recommendation to bring proceedings to enforce any rights of the United States."

An article in the December 2016 issue of *Texas Medicine* focused on physicians' concerns about the cost of complying with these requirements.

Existing Policy

TMA already maintains policy related to the issue of payment for interpreting services. The following statement was adopted at the 2017 meeting of the House of Delegates: 235.037 Public and Private Sector Funding of Interpretation Services for Limited English Speakers and American Sign Language: The Texas Medical Association will: (1) 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 series; (2) support expanded legislation that might arise concerning reimbursement for interpretive services for both American Sign Language and limited English speakers; and (3) advocate for increased access to qualified medical interpretive services for physicians (Res. 410-A-17).

Recommendation: That Resolution 411-A-17 not be adopted.

Related TMA Policy:

235.026 Medical Care and Fair Compensation: Medical care should not be an unfunded mandate from the government. If a governmental body provides access to health care, fair compensation to the physician must be provided (Amended Res.104-A-07; amended CSE Rep. 7-A-17).

235.027 Payment for Physician Work Product: A physician's time is not "free;" a physician's work product and time is justly compensable in accordance with standard business practices of learned professionals (Res. 409-A-07; reaffirmed CSE Rep. 7-A-17).

235.037 Public and Private Sector Funding of Interpretation Services for Limited English Speakers and American Sign Language: The Texas Medical Association will: (1) 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 series; (2) support expanded legislation that might arise concerning reimbursement for interpretive services for both American Sign

Language and limited English speakers; and (3) advocate for increased access to qualified medical interpretive services for physicians (Res. 410-A-17).

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).

Related AMA Policy:

Interpreters For Physician Visits D-90.999. Our AMA continues to monitor enforcement of those provisions of the ADA to assure physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients. (BOT Rep. 15, I-98; Reaffirmation I-03; Modified: BOT Rep. 28, A-13; Reaffirmation A-14)

Language Interpreters D-385.978. Our AMA will: (1) continue to work to obtain federal funding for medial interpreter 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. (Res. 907, I-03; Reaffirmed in lieu of Res. 722, A07; Reaffirmation A-09; Reaffirmation A-10; Reaffirmed: CMS Rep.5, A-11; Reaffirmed in lieu of Res. 110, A013; Reaffirmation A-17)

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924. 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 our 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. (BOT Rep. 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmed: CMS Rep.5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation A-17)

Discrimination Against Physicians by Health Care Plans H-285.985. Our AMA: … (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 judgement of the treating physician reasonably supports such a need.; (BOT Rep. 18, I-93; Appended by BOT Rep. 28, A-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed in lieu of Res. 110, A-13)

Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929. 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 problem imposed on physicians in private practice by the OCR language interpretation requirements. (BOT Rep. 25, I-01; Reaffirmation I-03; Reaffirmed: Res. 907, I-03; Reaffirmation A-09; Reaffirmation A-17)

REPORT OF COUNCIL ON SOCIOECONOMICS

CSE Report 6-A-18

Subject: Medicaid Work Requirements

Presented by: John T. Carlo, MD, Chair

Referred to: Reference Committee on Socioeconomics

Background

On Jan. 11, 2018, the Centers for Medicare & Medicaid Services (CMS) issued new policy guidance allowing states to obtain federal waivers to require certain working-age adult Medicaid enrollees to work in exchange for keeping their Medicaid benefits. CMS issued the guidance at the behest of 10 states that argued that implementing work requirements would make people healthier and more self-reliant.

In anticipation that Texas also would eventually request a waiver, the TMA Select Committee on Medicaid, CHIP and the Uninsured, which reports to the council, reviewed the guidance at its winter meeting.

Federal law gives the secretary of the U.S. Department of Health and Human Services broad discretion to waive some provisions of the Social Security Act as long as the waiver promotes the objectives of the Medicaid program. Many national Medicaid experts question the legality of the policy decision, noting that all other administrations — Republican and Democratic — have concluded that imposing such a requirement would be inconsistent with Medicaid's statutory mission to provide health care to eligible low-income people. Already, one lawsuit challenging the policy has been filed. Nevertheless, CMS is moving ahead. Within days of its announcement, it had approved waivers submitted by Kentucky, Indiana, and Arkansas and is reviewing some half-dozen others.

According to the guidance, states may not impose work requirements on pregnant women, people with disabilities, seniors, or the medically frail. Patients undergoing treatment for opioid or other substance use disorders must be given "reasonable accommodations," though CMS does not define what that means. The guidance goes on to encourage, but not require, states to broadly define "work" to include activities such as attending school or vocational training, caring for a child or parent, or volunteering, particularly because many Medicaid enrollees live in communities with high unemployment rates. Most of the state waivers submitted thus far include some exceptions, but there is considerable variation.

In announcing the new guidance, CMS Administrator Seema Verma said the intent of the new policy is to "make a positive and lasting difference in the health and wellness of our beneficiaries" — a goal everyone shares. Indeed, some studies confirm that people who work or who are otherwise engaged in meaningful community activities are happier and healthier. Yet the new policy belies the fact that the vast majority of working-age Medicaid patients already work and perpetuates a stereotype that people who are poor do not.

Moreover, the waivers approved thus far reveal that states will be allowed to suspend or deny Medicaid coverage for patients who fail to submit timely documentation of gainful employment or who do not work the minimum number of required hours. Indeed, under Arkansas' recently approved waiver, which will take effect in June, failure to submit proof of compliance could mean loss of Medicaid for up to nine months. In other words, states will be using onerous paperwork as a deterrent to Medicaid enrollment,

which will undermine the very health and well-being of the people the policy purports to help. After all, without coverage, chronically ill people will get sicker, not healthier.

TMA Select Committee members expressed strong support for any and all constructive initiatives to help low-income people obtain gainful employment or engage in other community activities. Yet of the low-income people who do not work, many face significant barriers to doing so, including low literacy level, lack of job training, poor health, or unreliable transportation. If Texas wants to encourage more Medicaid enrollees to work, it should help people overcome these barriers. Washington State, for example, helps people locate affordable housing and identifies employers who will work with people with a prior criminal history, another barrier to employment.

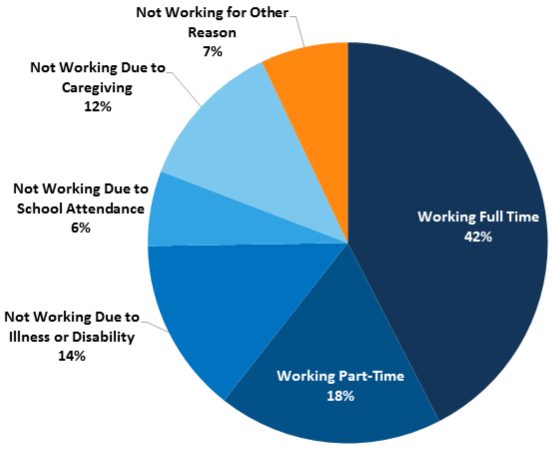
At the same time, the committee argued vigorously against any waiver imposing mandatory Medicaid work requirements, saying that organized medicine must not be a part of any effort to undermine health care coverage for low-income people by ensnarling them in red tape. TMA must work to improve coverage and eliminate burdensome paperwork.

Work Status of Adult Medicaid Enrollees

According to the Kaiser Family Foundation, 80 percent of adult Medicaid enrollees without a disability either work, live in a household with a working adult, attend school, or care for a child or relative. Of those who do not work, many face barriers to employment such as chronic illnesses, behavioral health disorders, inadequate job skills, or prior criminal history.

Figure 1

Work Status and Reason for Not Working Among Non-SSI, Nonelderly Medicaid Adults, 2016



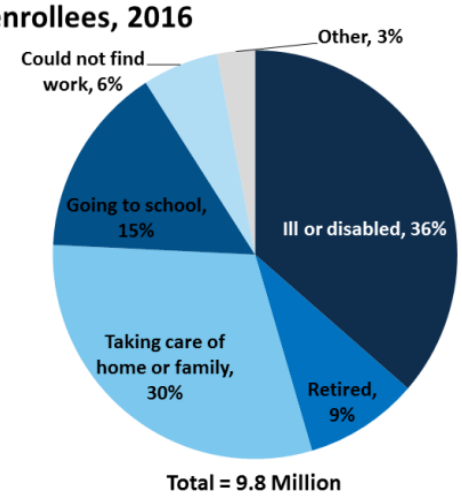
Total = 24.6 million

Notes: "Not Working for Other Reason" includes retired, could not find work, or other reason. Working Full-Time is based on total number of hours worked per week (at least 35 hours). Full-time workers may be simultaneously working more than one-job.
Source: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

THE HENRY J. KAISER FAMILY FOUNDATION

Figure 6

Main reasons for not working among non-SSI, adult Medicaid enrollees, 2016



NOTE: Includes nonelderly adults who do not receive Supplemental Security Income (SSI).
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

Because the majority of Medicaid patients work or live in a family where someone does, it is reasonable to ask why establishing a Medicaid work requirement would be problematic. But recent analyses of other programs where work is mandatory — Temporary Assistance for Needy Families and Supplemental Nutrition Assistance Program — show that such a policy would be deleterious to employed and unemployed low-income people alike.

For Medicaid enrollees who do work, irregular work hours may mean they will be unable to satisfy minimum weekly or monthly work requirements, potentially jeopardizing their health care coverage. In the states with approved Medicaid work requirements, working Medicaid patients must verify their work status as frequently as every two months, creating a lot of new paperwork for them and the state. For patients with behavioral health disorders or intellectual disabilities — or even just working multiple jobs — keeping up with the red tape will prove burdensome. In some communities, lack of access to reliable, fast internet service may impede patients' ability to complete paperwork electronically. Many people will fall through the cracks.

While people who qualify for federal Supplemental Security Income based on disability are exempt from any mandatory work requirement, rigid federal disability qualifications mean many people with chronic illnesses or conditions, such as cancer, depression, or multiple sclerosis, do not qualify for disability. Their ability to work, even a bit, results in their denial of disability status. Thus, someone in precarious health still could be required to work under the new guidance.

Lifetime Limits for Adult Medicaid Enrollees

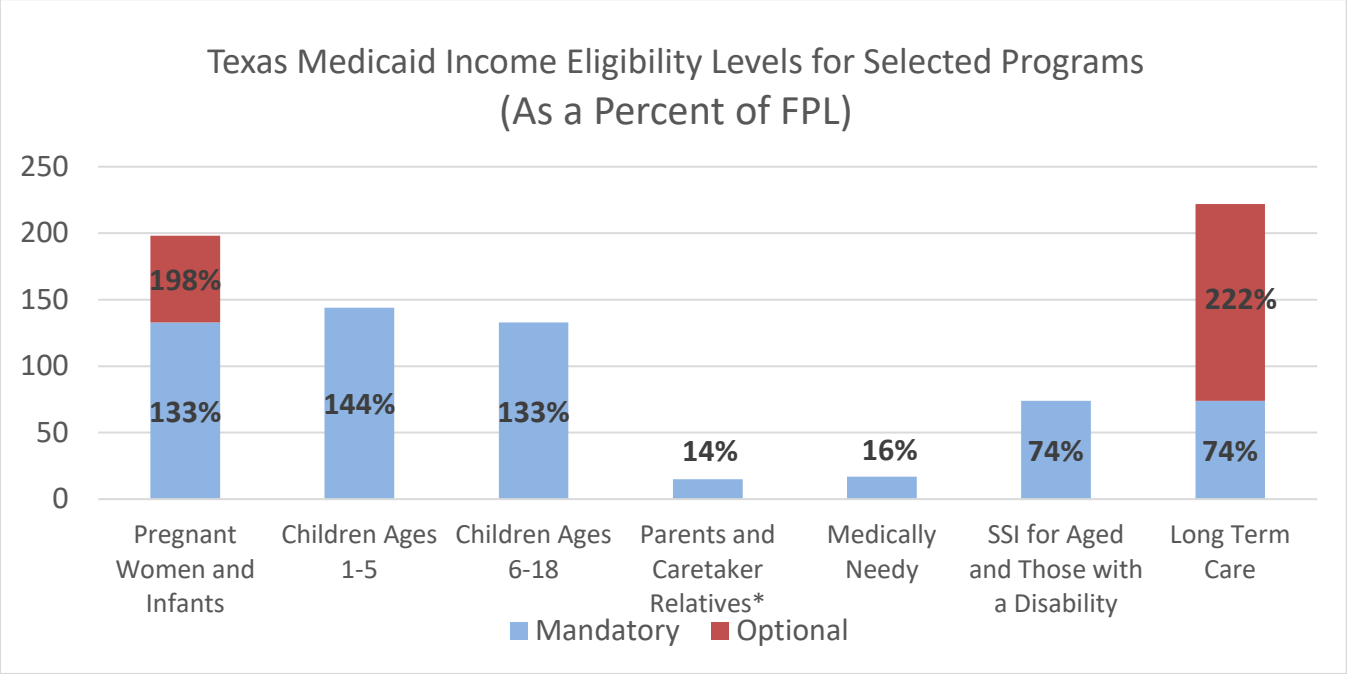
In addition to work requirements, CMS also is evaluating requests to impose lifetime limits on adults enrolled in Medicaid. Two states — Arizona and Kansas — recently submitted waiver requests to allow them to restrict Medicaid coverage to a maximum of five years and three years, respectively, even though for most low-income workers there is no other viable source of health care coverage absent Medicaid. According to the Census Bureau, nationally, 11 percent of the uninsured work in full or part time jobs, but for employers where health insurance is not offered or where it is not affordable. An arbitrary time limit would result in people enrolling in Medicaid when they need it, but dropping it when they don't, perversely increasing Medicaid costs. Moreover, it would punish people who have chronic health conditions or illnesses, such as diabetes or asthma, which will not end when Medicaid eligibility does.

While it too soon to say whether CMS will approve such requests, the committee felt it is important for the association to be on record against a policy that ill harm low-income patients and increase uncompensated care.

And as physicians well know, people who lose Medicaid still will need medical care. Many will turn to emergency departments for services, thus increasing uncompensated care for physicians and hospitals.

How Would the Medicaid Work Requirements Affect Texas?

CMS' new guidance applies primarily to states that expanded Medicaid to working-age parents and childless adults. Because Texas has not exercised that option, the waiver would apply to fewer than 200,000 Texans, though to ones who also are extremely vulnerable — very poor parents and former foster children under age 26. Currently, 147,000 poor parents are enrolled in Texas Medicaid. To qualify, parents must earn less than $320 per month, meaning a mother working part time at minimum wage — $7.25 per hour — earns too much to qualify (though Texas has the option to use federal Medicaid funds to extend coverage up to 138 percent of the federal poverty level using a private-sector strategy).



*In 2018, federal poverty level is $12,140 for an individual and $20,780 for a family of 3
Source: TX HHSC

If implemented, a waiver would require the state to establish new bureaucratic infrastructure to certify patients' compliance, likely with a high price tag. Kentucky estimates building the information technology system necessary to verify its Medicaid enrollees' work status will cost $170 million.

Furthermore, it should be noted that if Texas ever were to expand Medicaid consistent with TMA policy (policy 190.032), the intent of such coverage would be to benefit the working poor. As noted above, many low-income workers lack health insurance because their employer does not provide it or they cannot afford it. Imposing a bureaucracy that then could be used to deny coverage because a patient didn't submit the right paperwork at the right time – or could not work a minimum number of hours - would be contrary to TMA's goals.

It also must be pointed out that by not exercising its option to use federal Medicaid funds to extend health care coverage to the working poor as authorized by the Affordable Care Act, Texas actually perversely

discourages very poor parents with chronic illnesses or conditions from working since by doing so they will then earn too much to remain eligible for Medicaid.

Thus far, only a handful of Texas lawmakers have expressed interest in pursuing a federal waiver to implement a Medicaid work requirement. But as other states submit waivers, it undoubtedly will pique legislators' interest. Of the 10 waivers submitted to CMS thus far, five are from states that like Texas chose not cover low-income adults using Medicaid funds. They are seeking waivers to impose work requirements on even the poorest parents.

Conclusions

Based on the Select Committee's review, the council believes implementation of any Medicaid waiver that would increase programmatic bureaucracy while also undermining health care coverage for low-income Texans would be antithetical to TMA's mission to improve the health of all Texans.

Depriving low-income people of health care will undermine the very health and well-being of the people the waivers purport to help. People who lose Medicaid still will need medical care, but few will be able to pay. And high out-of-pocket costs will impede people with chronic conditions from continuing their medications and treatment. Depriving poor parents of health care coverage also would have the unintended effect of increasing poverty, not moderating it. Medical debt is a key contributor to families' financial strife. Instead of using their limited discretionary dollars to save for a rainy day, many families instead will become saddled with medical debt that may take years to pay off. For physicians, such a policy also would contribute to higher uncompensated care costs.

The adoption of punitive Medicaid work requirements in lieu of more constructive strategies to help people find and keep jobs will not only jeopardize low-income patients' access to care but also increase paperwork and uncompensated care for physicians. Several approved waivers require patients to obtain physician attestation of their disability or illness every few months. If patients are locked out of coverage for some portion of the year, it will result in cost-shifting to physicians and hospitals. In rural and border communities, cost-shifting could be significant because those communities have more Medicaid enrollees and higher unemployment rates.

Support for any lifetime Medicaid limits also would punitively affect poor and low-income Texans access to health care while imposing hardships on physicians by increasing uncompensated care.

For all these reasons, the council recommends TMA not support any Medicaid waiver to implement mandatory work requirements or to impose life time Medicaid limits. Instead, the association should work with the legislature, state agencies, and CMS to find constructive strategies to help patients overcome barriers to work or meaningful community engagement.

Recommendation 1: That the Texas Medical Association oppose any federal Medicaid waiver seeking to impose mandatory work requirements, but instead collaborate with lawmakers, the Texas Health and Human Services Commission, and the Centers for Medicare & Medicaid Services to support constructive measures to help Medicaid enrolled and eligible patients overcome barriers that prevent them from working or engaging in other meaningful community activities.

Recommendation 2: That the Texas Medical Association oppose efforts to impose lifetime limits on adult Medicaid enrollees.

Recommendation 3: That the Texas Medical Association oppose any policy or regulation that punitively limits access to affordable health care for Medicaid-eligible patients.

Sources:

1. Centers for Medicare & Medicaid Services. Memo to state Medicaid directors RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries. Jan. 11, 2018. www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf.
2. Kaiser Family Foundation. Medicaid and Work Requirements: New Guidance, State Waiver Details and Key Issues. MaryBeth Musumeci, Rachael Garfield, and Robin Rodowizc. Jan. 16, 2018. www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements-new-guidance-state-waiver-details-and-key-issues/
3. Texas Medicaid and CHIP in Perspective, 11th edition

Supplement

REPORT OF COMMITTEE ON EMERGENCY MEDICAL SERVICES AND TRAUMA

CM-EMST Report 2-A-18

Subject: Policy Review

Presented by: Veer Vithalani, MD, Chair

Referred to: Reference Committee on Socioeconomics

House of Delegates policies in the association's Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the committee with recommendations for retention, amendment, and deletion.

The committee recommends retaining the following policies:

100.022 **Emergency Psychiatric Services**: The Texas Medical Association advocates additional funding to sustain and expand recent state investments to redesign mental health crisis services as well as to expand the availability of community-based mental health care, including prevention and early intervention strategies (CM-EMS Rep. 1-A-08).

100.023 **Holding Admitted Patients in Crowded Emergency Departments**: The Texas Medical Association will work with hospitals and health care organizations to develop appropriate mechanisms to facilitate availability of inpatient beds, which would include a workable plan to achieve prompt transfer of admitted patients to inpatient units during "full capacity periods" in the emergency department (ED), when the number of patients needing evaluation or treatment in the ED is equal to or exceeds the ED treatment space capacity (Res. 203-A-08).

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).

100.026 **Emergency Department On-Call Physicians**: The Texas Medical Association will work with health care organizations and governmental agencies to ensure adequate emergency department on-call specialist access; maintain current liability protection for treatment of emergency medical conditions; and ensure appropriate physician compensation, given existing and special hospital funding for emergency services (Amended Res. 206-A-08).

Recommendation 1: Retain.

The committee further recommends amending policy 100.024 Regulation of Free-Standing Emergency Departments.

In 2009, the Texas Medical Association in partnership with the Texas College of Emergency Physicians, supported enactment of House Bill 1357 establishing the minimum statutory requirements for free-standing emergency departments. Since the Texas legislature enacted the law, there is no longer a need for TMA to pursue legislation regulating these facilities.

However, the committee continues to strongly favor Texas' current statutory framework and recommends policy as follows:

100.024 **Regulation of Free-Standing Emergency Departments:** The Texas Medical Association supports Texas' statutory framework ~~legislation~~ regulating the operation of free-standing emergency departments (FSED) that stipulates, among other provisions, that an FSED must ~~would include~~ (1) provide medical screening and stabilization services for all patients seeking emergency services; (2) 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; (3) ~~a requirement to~~ be open 24 hours a day, seven days a week, every day of the year~~,~~; (4) maintain full-time coverage by a physician(s) either board certified in emergency medicine or otherwise qualified to provide emergency medical care; and ~~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~~ (5) be certified ~~require certification~~ by the Joint Commission or other such independent accreditation body. TMA will continue to collaborate with the Texas College of Emergency Physicians to review and comment on any ~~regarding~~ proposed FSED-related legislation or regulation and will oppose any proposal ~~proposed regulations~~ that is onerous or goes against TMA policy (Amended Res. 204-A-08).

Recommendation 2: Retain as amended.

The committee recommends deletion of the following policy as it is considered redundant (see policy 100.024):

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 (CM-EMS Rep. 1-A-08).

Recommendation 3: Delete.

Supplement

REPORT OF COMMITTEE ON MEDICAL HOME AND PRIMARY CARE

CM-MHPC Report 2-A-18

Subject: Policy Review

Presented by: Lindsay Botsford, MD, Chair

Referred to: Reference Committee on Socioeconomics

House of Delegates policies in the association's Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the committee with recommendations for retention, amendment, and deletion.

The committee recommends retaining the following policy:

255.004 **Patient-Centered Medical Home**: A patient centered medical home (PCMH) is a primary care physician or team who ensures that patient care is accessible, coordinated, comprehensive, patient-centered, and culturally relevant through the direct provision, coordination, or arrangement of health care or social support services as indicated by the patient's individual medical needs and the best-available medical evidence.

Principles of a patient centered medical home (as articulated by AAFP, the American College of Physicians, Association of American Physicians, and American Osteopathic Association) are as follows.

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact and continuous and comprehensive care;

Physician-directed medical practice - the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation - the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life, acute care, chronic care, preventive services, and end-of-life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home, meaning (1) practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership among physicians, patients, and the patients' families; (2) evidence-based medicine and clinical decision-support tools guide decision making; (3) physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement

and improvement; (4) patients actively participate in decision-making, and feedback is sought to ensure patients' expectations are being met; (5) information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication; (6) practices go through a voluntary recognition process by an appropriate nongovernmental entity to demonstrate they have the capabilities to provide patient-centered services consistent with the medical home model; and (7) patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours, and new options for communication among patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. It should (1) reflect the value of patient-centered care management work by physicians and nonphysician staff that falls outside of the face-to-face visit; (2) pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources; (3) support adoption and use of health information technology for quality improvement; (4) support provision of enhanced communication access such as secure e-mail and telephone consultation; (5) recognize the value of physician work associated with remote monitoring of clinical data using technology; (6) allow for separate fee-for-service payments for face-to-face visits (payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits); and (7) recognize case mix differences in the patient population being treated within the practice (SC-MCU Rep. 1-A-08).

Recommendation: Retain.

Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 401
A-18

Subject: Physicians Allowed to Delegate Ability to Enter EHR Data

Introduced by: McLennan County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Novitas Solutions, the Medicare administrative contractor for Texas, declared its interpretation of the Centers for Medicare & Medicaid Services policy to be that no one besides the treating physician may enter any data into the electronic health record (EHR) under the chief complaint (CC) and history of present illness (HPI) sections, effective Jan. 1, 2018; and

Whereas, Physicians have relied on others such as scribes, nurses, and health information transcriptionists to help produce a complete and accurate medical record, and in fact, physicians have routinely hired such workers specifically for the purpose of completing the EHR, including the CC and HPI; and

Whereas, Any information obtained from the patient interview prior to the physician interviewing the patient would be lost if details of those initial interviews cannot be entered into the medical record; and

Whereas, Physicians have always known they are responsible for every word in their clinical encounter and subsequent medical record, regardless of who actually entered the data; and

Whereas, Regulations forbidding other medical personnel from entering data under the CC and HPI would dramatically increase the physician workload and time commitment for each and every patient, which would be detrimental to both the patient and the physician; and

Whereas, The idea that scribes, nurses, health information transcriptionists, and the like are incapable of entering information under the CC or HPI seems ignorant of the fact that they routinely fill out other equally important portions of the medical chart; and

Whereas, Reducing the physician paperwork and EHR burden is a stated goal of organized medicine, and defending the physician's ability to delegate such authority to others who are capable seems consistent with the direction EHR reform is trending; therefore be it

RESOLVED, That the Texas Medical Association support the physician's ability to delegate data entry into any part of the physician's notes in the electronic health record (EHR), including the chief complaint and history of present illness sections; and be it further

RESOLVED, That the Texas Medical Association ask Novitas Solutions to reverse its (erroneous) interpretation — mandating that physicians personally enter data into the physician notes of an EHR — of the Centers for Medicare & Medicaid Services (CMS) policy given that other Medicare administrative contractors have not made such restrictions and CMS does not make such restrictions concerning the chief complaint and history of present illness sections of the EHR; and be it further

RESOLVED, That the Texas Medical Association endorse the policy of physicians hiring appropriately trained assistants such as scribes, nurses, health information transcriptionists to enter data into any and all portions of the medical record the physician deems appropriate.

Related TMA Policy:
265.012 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 4 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.

5. TMA supports the study and evaluation of the potential impact that physician efforts directed towards compliance with unduly burdensome state and federal regulation may have on patient care. These new compliance burdens compete for the physician's attended and limited resources and may distract the physician from patient care (Amended Res. 402-A-05; amended CPMS Rep. 3-A-07; substituted CPMS Rep. 2-A-10; amended CPMS Rep. 2-A-13; amended CPMS Rep. 1-A-14).

Related AMA Policy:

3.3.2 Confidentiality & Electronic Medical Records

Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.

Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:

(a) Choose a system that conforms to acceptable industry practices and standards with respect to:

(i) restriction of data entry and access to authorized personnel;
(ii) capacity to routinely monitor/audit access to records;
(iii) measures to ensure data security and integrity; and
(iv) policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance.

(b) Describe how the confidentiality and integrity of information is protected if the patient requests.

(c) Release patient information only in keeping with ethics guidance for confidentiality.

AMA Principles of Medical Ethics: V

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

Physician Decision-Making in Health Care Systems H-285.954

AMA policy states: (1) That certain professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician regardless of the practice setting, whether it be a health care plan, group practice, integrated or non-integrated delivery system or hospital closed department, whether in primary care or another specialty, either unilaterally or with consultation from the plan, group, delivery system or hospital. Such decisions include, but are not limited to, the following: (a) What diagnostic tests are appropriate. (b) When and to whom physician referral is indicated. (c) When and with whom consultation is indicated. (d) When non-emergency hospitalization is indicated. (e) When hospitalization from the emergency department is indicated. (f) Choice of service sites for specific services (office, outpatient department, home care, etc.). (g) Hospital length of stay. (h) Frequency/length of office/outpatient visits or care. (i) Use of out-of formulary medications. (j) When and what surgery is indicated. (k) When termination of extraordinary/heroic care is indicated. (l) Recommendations to patients for other treatment options, including non-covered care. (m) Scheduling on-call coverage. (n) Terminating a patient-physician relationship. (o) Whether to work with, and what responsibilities should be delegated to, a mid-level practitioner. (p) Determination of the most appropriate treatment methodology. (2) The AMA encourages state medical associations to consider development and wide dissemination of guidelines for the extent of practicing physician involvement in plan, group, system or hospital department medical decisions and policies. Such guidelines should be relevant to their jurisdiction, allow for variation in plan, group, system or hospital department sponsorship and structure, and optimize patient care. (3) The AMA encourages organizations and entities that accredit or develop and apply performance measures for health plans, groups, systems or hospital departments to consider inclusion of plan, group, system or hospital department compliance with any applicable state medical association or medical staff-developed decision-making guidelines in their evaluation criteria. (4) The AMA encourages physicians in integrated health plans and systems to have a functioning medical staff structure in place.

Physician Assistants and Nurse Practitioners H-160.947
Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

(1) The physician is responsible for managing the health care of patients in all settings.

(2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.

(3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.

(4) The physician is responsible for the supervision of the physician assistant in all settings.

(5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.

(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.

(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.

(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.

The CMS Electronic Medical Records Initiative Should Not Be Used To Detect Alleged Fraud by Physicians D-175.985
1. Our AMA will (A) communicate its concerns about the plan recently announced by the Centers for Medicare and Medicaid Services (CMS), in which CMS is to use data from the electronic medical record incentive program in the pursuit of fraud, waste and abuse; and (B) seek active involvement in the drafting of all program directives for CMS's electronic medical record initiative, including all directives about potential data capture and subsequent audit processes.

2. Our AMA will lead an effort in concert with the Centers for Medicare and Medicaid Services to establish specific guidance to be utilized by entities that audit documentation generated by an electronic health record.

3. Such guidance will provide specific protocols used by Medicare and Medicaid auditors to allege a service is not reasonable and necessary based on the generation of an electronic health record.

4. Our AMA will inform state and specialty societies about available AMA resources to assist physicians with audits of electronic health records and prominently feature on their website information about methods, resources, and technologies related to appeals of electronic health record audits and Medicare and Medicaid overpayment recoveries as a members-only benefit.

5. Our AMA believes that the use of time-saving features, such as cloning, templates, macros, "pull forward technology", auto-population and identical language in EMRs, by itself is not an indication of inaccurate documentation or incorrect coding.

6. Our AMA believes that audit results that imply incorrect coding must specifically indicate which portion of the chart language either does not accurately reflect the office visit or reflects unnecessary care.

7. Our AMA will: (1) develop guidelines in conjunction with the Centers for Medicare & Medicaid Services to provide clear and direct guidance to physicians concerning the permissible use for coding and billing of electronic health record (EHR) clinical documentation tools, such as templates, macros, cutting and pasting, and cloning, and (2) study the impact of EHR clinical documentation tools and shortcuts on patient safety, quality of care and safe harbor laws.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 402
A-18

Subject: Opposition to Medicaid Work Requirements

Introduced by: Ryan Van Ramshorst, MD, Texas Pediatric Society

Referred to: Reference Committee on Socioeconomics

Whereas, The Centers for Medicare & Medicaid Services recently released guidance allowing states to pursue Medicaid waivers requiring adult Medicaid patients to work in exchange for health care benefits, excluding women who are pregnant, patients with disabilities, and seniors; and

Whereas, The adults covered by Texas Medicaid who potentially could be affected by such a waiver are the most vulnerable, including parents earning less than $3,800 per year, young adults who recently aged out of foster care, or women receiving breast or cervical cancer treatment or preventive health services; and

Whereas, Among nonelderly adults with Medicaid coverage nationally, nearly eight in 10 live in working families and a majority are working themselves; and

Whereas, Among nonelderly adults who are not working, the majority are enrolled in school, taking care of a child or relative, or searching for work; and

Whereas, Studies show children's access to care and health outcomes improve when their parents have health coverage, too; and

Whereas, Imposing work requirements in the Medicaid program constitutes the creation of unnecessary state bureaucracy and red tape for both low-income patients and their physicians, as well as barriers to accessing health care; therefore be it

RESOLVED, That the Texas Medical Association apply all appropriate resources to oppose Medicaid work requirements to ensure that vulnerable, low-income adults with children and other covered populations continue to receive necessary medical services and that Texas does not increase uncompensated care for physicians.

Related TMA Policy:
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 (abbreviated): 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. … (AHCM-MAC Rep. 1-1-04; amended SC-MCU Rep. 1-A-15).

Related AMA Policy:

Health Care Access for Medicaid Patients H-385.921

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. 132-A-14; reaffirmed in lieu of Res. 808, I-14; reaffirmation A-15).

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 403
A-18

Subject: Underreporting of Optometric Diabetic Eye Examinations to Treating Physicians

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Payment methodologies under Medicare are in evolution; and

Whereas, the Merit-Based Incentive Payment System (MIPS) determines Medicare payments to physicians based on certain "quality" measures; and

Whereas, Documentation of an annual diabetic retinal examination for diabetic patients is such a quality measure; and

Whereas, Many diabetic patients receive their eye care from optometrists; and

Whereas, Many patients are unable to provide to their physicians the name or address of their optometrist; and

Whereas, It is very uncommon for optometrists to send their diabetic eye examination reports to physicians who treat these diabetic patients; and

Whereas, This failure to provide such reports results in a break in the continuity of care that is essential to proper diabetic management; and

Whereas, Such failure to communicate with the treating physician results in incomplete diagnosis information regarding the eye complications of diabetes; and

Whereas, Such incomplete information may lead to inadequate medical management of diabetes, which is a leading cause of blindness; and

Whereas, The lack of adequate documentation of diabetic eye disease results in underreporting of such disease severity to the Centers for Medicare & Medicaid Services, which in turn results in (1) inadequate Medicare funding for future diabetic eye services (causing potential harm to the patient), and (2) lower Medicare payments to physicians who treat complicated diabetic patients; therefore be it

RESOLVED, That the Texas Medical Association establish better affiliations with the Texas Optometry Board to develop rules around conditions that need to be reported to the patient's physician; and be it further

RESOLVED, That this resolution be forwarded to the American Medical Association for similar action.

Related TMA Policy:
None found.

Related AMA Policy:

Allied Health Professionals 10.5

Physicians often practice in concert with optometrists, nurse anesthetists, nurse midwives, and other allied health professionals. Although physicians have overall responsibility for the quality of care that patients receive, allied health professionals have training and expertise that complements physicians'. With physicians, allied health professionals share a common commitment to patient well-being.

In light of this shared commitment, physicians' relationships with allied health professionals should be based on mutual respect and trust. It is ethically appropriate for physicians to:

(a) Help support high quality education that is complementary to medical training, including by teaching in recognized schools for allied health professionals.

(b) Work in consultation with or employ appropriately trained and credentialed allied health professionals.

(c) Delegate provision of medical services to an appropriately trained and credentialed allied health professional within the individual's scope of practice.

AMA Principles of Medical Ethics: I,V,VII

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

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 404
A-18

Subject: Opposition to Pain Score as Contributor to Hospital Financial Incentives

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey has become a relied upon metric for patient satisfaction; and

Whereas, HCAHPS, beyond serving as a tool for hospital self-evaluation, actually incentivizes higher scores in order to receive Medicare financial reimbursement for the hospitals; and

Whereas, Sixteen percent of emergency physicians have stated their employment was threatened by low satisfaction scores, and 27 percent stated their income was affected by patient satisfaction scores; and

Whereas, Multiple HCAHPS survey questions assess how often and how well the patient's pain was managed and alleviated; and

Whereas, A marked rise in opioid prescriptions for patients with chronic non-cancer pain and subsequent opioid misuse in the last decade, parallels with the implementation in 2006 of the HCAHPS survey as a method for evaluating hospitals and providing them Medicare financial reimbursement; and

Whereas, Patients complete the HCAHPS survey towards the end of their hospital stay, coinciding with post-discharge opioid prescriptions, and the odds of a patient's satisfaction were 4.86 times greater if the patient stated that his or her pain was controlled; and

Whereas, The timing of the survey and relevant questions about pain suggest the potentiality of the HCAHPS measures incentivizing physicians and clinicians to unnecessarily prescribe opioids after patient discharge to increase HCAHPS ratings and Centers for Medicare & Medicaid Services (CMS) financial reimbursement; and

Whereas, CMS will remove the criteria of pain from having any bearing on hospital payments and reimbursement starting in 2018; therefore be it

RESOLVED, That the Texas Medical Association oppose the allocation of financial incentives for high patient satisfaction scores that weigh patient-rated treatment of pain against other factors involved in patient care.

Related TMA Policy:
260.092 Responsible Opioid Prescribing for Pain Management: The Texas Medical Association supports multidimensional strategies to optimize the treatment of pain and works to educate Texas physicians about the latest evidence-based literature on responsible opioid analgesia management with the goal of reducing the risk to patients and enhancing the public safety regarding opioid use, misuse, abuse, diversion, and nontherapeutic prescribing (Res. 313-A-12).

280.034 Pain Management: The Texas Medical Association will: (1) support more effective promotion and dissemination of educational materials for physicians on prescribing for pain management; (2) take a leadership role in resolving conflicting state and federal agencies' expectations in regard to physician responsibility in pain management; (3) coordinate its initiatives with those state medical associations and national medical specialty societies that have already established pain management guidelines; and (4) will disseminate Council on Science and Public Health Report 5 (A-06), "Neuropathic Pain," to physicians, patients, payers, legislators, and regulators to increase their understanding of issues surrounding the diagnosis and management of maldynia (neuropathic pain) (CM-C Rep. 3-A-08).

265.017 Pay-for-Performance Principles and Guidelines: Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five American Medical Association principles:

Ensure quality of care. Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality-of-care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.

Foster the patient-physician relationship. Fair and ethical PFP programs support the patient-physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

Offer voluntary physician participation. Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of nonparticipating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

Use accurate data and fair reporting. Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment, and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

Provide fair and equitable program incentives. Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

Guidelines for Pay-for-Performance Programs
Safe, effective, and affordable health care for all Americans is the American Medical Association's goal for our health care delivery system. AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment AMA's Principles for Pay-for-Performance Programs and provide AMA leaders, staff, and members operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care
The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

Evidence-based quality-of-care measures must be the primary measures used in any program.

All performance measures used in the program must be defined prospectively and developed collaboratively across physician specialties.

Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.

All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.

Performance measures should be scored against both absolute values and relative improvement in those values.

Performance measures must be subject to the best available risk adjustment for patient demographics, severity of illness, and comorbidities.

Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.

Performance measures must be selected for clinical areas that have significant promise for improvement.

Physician adherence to PFP program requirements must conform with improved patient care, quality, and safety.

Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.

PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.

PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.

Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing also should analyze for patient deselection. If implemented, the program must be phased in over an appropriate period of time to enable participation by any willing physician in affected specialties.

Plans that sponsor PFP programs must explain these programs prospectively to the patients and communities covered by them.

Patient-Physician Relationship

Programs must be designed to support the patient-physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.

Programs must not cause conditions that limit access to improved care.

Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socioeconomic groups, as well as those with specific medical conditions, or the physicians who serve these patients.

Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

Programs must neither directly nor indirectly encourage patient deselection.

Programs must recognize outcome limitations caused by patient noncompliance, and sponsors of PFP programs should attempt to minimize noncompliance through plan design.

Physician Participation

Physician participation in any PFP program must be completely voluntary.

Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.

Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.

Programs should be available to any physicians and specialties wishing to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.

Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).

Programs should provide physicians tools to facilitate participation.

Programs should be designed to minimize financial and technological barriers to physician participation.

Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.

Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.

Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.

Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).

The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not cause financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a nonpunitive manner.

Programs should use accurate administrative data and data abstracted from medical records.

Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.

Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

Physicians should be assessed in groups and/or across health care systems, rather than individually when feasible.

Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.

Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.

Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards
Programs must be based on rewards and not on penalties.

Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.

Programs must offer financial support to physician practices that implement IT systems or software that interacts with aspects of the PFP program.

Programs must finance bonus payments based on specified performance measures with supplemental funds.

Programs must reward all physicians who actively participate in the program and who achieve prespecified absolute program goals or demonstrate prespecified relative improvement toward program goals.

Programs must not reward physicians based on ranking compared with other physicians in the program.

Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.

Programs must not financially penalize physicians based on factors outside of the physician's control.

Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

TMA opposes private payer, congressional, or Centers for Medicare & Medicaid Services pay-for-performance initiatives if they do not meet the AMA's Principles and Guidelines for Pay for Performance (BOT Rep. 14-A-08).

AMA Policy

Improve the HCAHPS Rating System D-450.960

Our AMA will urge the Centers for Medicare & Medicaid Services to modify the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scoring system so that it assigns a unique value for each rating option available to patients.

Pain Management and the Hospital Value-Based Purchasing Program D-450.962

1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to: (a) evaluate the relationship and apparent disparity between patient satisfaction, using the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) and Emergency Department Patient Experience of Care (ED-PEC) survey, and hospital performance on clinical process and outcome measures used in the hospital value based purchasing program; and (b) reexamine the validity of questions used on the HCAHPS and ED-PEC surveys related to pain management as reliable and accurate measures of the quality of care in this domain.
2. Our AMA urges CMS to suspend the use of HCAHPS and ED-PEC measures addressing pain management until their validity as reliable and accurate measures of quality of care in this domain has been determined.

Sources:

1. Zusman, Edie E. "HCAHPS replaces Press Ganey survey as quality measure for patient hospital experience." Neurosurgery71.2 (2012): N21-N24.
2. Hachem, Fadi, et al. "The relationships between HCAHPS communication and discharge satisfaction items and hospital readmissions." *Patient Experience Journal* 1.2 (2014): 71-77.
3. Centers for Medicare and Medicaid Services. "HCAHPS: patients' perspectives of care survey. 2014." (2015).
4. Lee, Jay S., et al. "Postoperative opioid prescribing and the pain scores on hospital consumer assessment of Healthcare Providers and Systems Survey." *JAMA* 317.19 (2017): 2013-2015.

5. Häuser, Winfried, Stephan Schug, and Andrea D. Furlan. "The opioid epidemic and national guidelines for opioid therapy for chronic noncancer pain: a perspective from different continents." *Pain Reports* 2.3 (2017): e599.
6. Hanna, Marie N., et al. "Does patient perception of pain control affect patient satisfaction across surgical units in a tertiary teaching hospital?" *American Journal of Medical Quality* 27.5 (2012): 411-416.

Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 405
A-18

Subject: Compensation to 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, Other professionals, such as attorneys and accountants, bill and get paid for time spent personally and by their staff in providing services for a client; 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

Time typically spent	**CPT Code**
Up to 5 minutes	99211
Up to 10 minutes	99212
Up to 15 minutes	99213
Up to 25 minutes	99214
Up to 40 minutes	99215

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 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.

Related 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; reaffirmed CSE Rep. 7-A-17).

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).

Related AMA Policy:

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.

Fee for Services When Fulfilling Third Party Payer Requirements H-385.984

The AMA believes that the attending physician should perform without charge simple administrative services required to enable the patient to receive his benefits. When more complex administrative services are required by third parties, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage, it is the right of the physician to be recompensed for his incurred administrative costs.

Reasonable Charge for Preauthorization H-385.948

The AMA strongly supports and advocates fair compensation for a physician's administrative costs when providing service to managed care patients.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 406
A-18

Subject: Supporting the Reclassification of Complex Rehabilitation Technology

Introduced by: Resident and Fellow Section

Referred to: Reference Committee on Socioeconomics

Whereas, complex rehabilitation technology (CRT) products are medically necessary devices individually configured to meet a person's unique needs, such as custom manual and powered wheelchairs, adaptive seating systems, alternative positioning systems, and other mobility devices; and

Whereas, The primary end users of CRT equipment are individuals with substantially disabling and chronic conditions resulting in long-term disabilities, necessitating the use of properly fitted CRT for maximum independence in mobility and activities of daily living and leisure; and

Whereas, the Centers for Medicare & Medicaid Services (CMS) currently classifies CRT under the broad category of durable medical equipment (DME) and does not assign it a distinct payment category under the Medicare program; and

Whereas, The current classification system does not provide the ability to distinguish technological differences between CRT and other DME and often results in limited access to CRT; and

Whereas, Congress and CMS have recognized the benefit of a separate classification for "complex rehabilitation power wheelchairs" and related accessories for individuals with "complex chronic conditions that are substantially disabling or life threatening [and] have a high risk of hospitalization or other significant adverse health outcomes" within the Medicare Improvements for Patients and Providers Act of 2008; and

Whereas, the Medicare program is commonly the model other payers use to establish their own coverage and pricing policies; and

Whereas, The current system allows nontrained providers to prescribe DME, which often results in improperly fitted CRT; and

Whereas, In reclassifying CRT, additional requirements could be implemented such as limiting CRT prescribers to CRT-trained providers to ensure properly fitted CRT; and

Whereas, DME typically is furnished for use in the home, but CRT is frequently required for optimal transition from a skilled nursing facility or other long-term care facility to a home or a community setting; and

Whereas, An individual requiring a stay at a long-term care facility under Medicare Part A will not be provided DME under Medicare Part B during the stay, and many long-term care facilities do not provide CRT due to cost or lack of expertise with CRT configuration; and

Whereas, Limited access to CRT puts an individual at risk for reduced independence and greater susceptibility to illness. The inability to independently reposition and care for oneself can lead to preventable diseases such as pressure ulcers, resulting in extended institutionalization, increased morbidity and mortality, increased readmission rates, and increased medical costs; therefore be it

RESOLVED, That the Texas Medical Association support the Centers for Medicare & Medicaid Services reclassifying complex rehabilitation technology equipment into its own distinct payment category under the Medicare program to improve access to individuals with substantially disabling and chronic conditions.

Related 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).

270.002 Rehabilitation Services: The Texas Medical Association supports increased funding and legislative action for rehabilitation services to be provided in all Medicaid, managed care, or other carrier basic benefit packages, and that benefits include acute and subacute rehabilitation, home care, outpatient rehabilitation, and durable medical equipment for physically challenged patients (Committee on Rehabilitation, p 140, A-93; reaffirmed CSE Rep. 1-A-05; reaffirmed CSE Rep. 1-A-15).

270.003 Rehabilitation Services in Managed Care Programs: Rehabilitation services should be required in benefits of managed care programs, Medicaid, and any other insurance carriers in order to meet the needs of the disabled population (Committee on Rehabilitation, p 170, I-94; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

Related AMA Policy:

Durable Medical Equipment Requirements H-330.945

Our AMA will: (1) continue to seek legislation to prohibit unsolicited contacts by durable medical equipment suppliers that recommend medically unnecessary durable medical equipment to Medicare beneficiaries; (2) affirm the concept that members of a physician-led interprofessional health care team be enabled to perform delegated medical duties, including ordering durable medical equipment, that they are capable of performing according to their education, training and licensure and at the discretion of the physician team leader; (3) advocate that the initiators of orders for durable medical equipment should be a physician, or a nurse practitioner or physician assistant supervised by a physician within their care team, consistent with state scope of practice laws; and (4) reaffirm the concept that physicians are ultimately responsible for the medical needs of their patients.

Protect Medicare Beneficiary Access to Complex Rehabilitation Wheelchairs D-330.907

Our AMA strongly encourages the Centers for Medicare and Medicaid Services (CMS) to refrain from implementing policies on January 1, 2016 that would curtail access to complex rehabilitation technology (CRT) wheelchairs and accessories by applying competitively bid prices to these specialized devices. In the event that CMS does not refrain from implementing policies limiting access to CRT wheelchairs, our AMA will encourage Congress to support legislation (e.g. H.R. 3229) that would provide a technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs.

Sources:

1. Salzberg, C. A., D. W. Byrne, et al. A new pressure ulcer risk assessment scale for individuals with spinal cord injury. *Am J Phys Med Rehabil* 75(2): 96-104, 1996.

2. Pressure Ulcer Prevention and Treatment Following Spinal Cord Injury: A Clinical Practice Guidelines for Health-Care Professionals. Consortium for Spinal Cord Medicine, 2014.

Relevant pending legislation:

Ensuring Access to Quality Complex Rehab Technology Act of 2017 (H.R.750).

Distributed at Meeting
(Originally Resolution 110-A-18)

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 407
A-18

Subject: Medical Necessity Decisions Are the Practice of Medicine

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Payer peer-to-peer (payer physician to practicing physician) utilization reviews regarding prior authorization adverse determinations have increased in recent years; and

Whereas, Peer-to-peer utilization reviews are predominantly decisions on medical necessity; and

Whereas, Practicing medicine, according to Texas Occupations Code Chapter 151.002 (13), "means the diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method, or the attempt to effect cures of those conditions, by a person who: (A) publicly professes to be a physician or surgeon, or (B) directly or indirectly charges money or other compensation for those services;" and

Whereas, Based on the above definition, medical necessity decisions are the practice of medicine by virtue of the fact that they effect cures; and

Whereas, To be a physician or surgeon in Texas you must have a Texas medical license; and

Whereas, At times, the 'payer peer' in the peer-to-peer review is not of the same or similar specialty as the practicing physician, not licensed in Texas, and not a physician or surgeon; and

Whereas, The Texas Occupations Code (Medical Practice Act) currently does not have clear language stating that a medical necessity decision is the practice of medicine and therefore must be made by a physician licensed to practice in Texas, and

Whereas, Texas Insurance Code Title 14, Chapter 4201, Subchapter A, Section 4201.002 (1), regarding utilization review, allows a "utilization review agent" to determine that health services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational; and

Whereas, Texas Insurance Code Title 14, Chapter 4201, Subchapter A, Section 4201.002 (14) defines a "utilization review agent" as an entity that conducts utilization review for (A) an employer with employees in this state who are covered under a health benefit plan or health insurance policy; (B) a payer; or (C) an administrator holding a certificate of authority under Chapter 4151; and

Whereas, Texas Insurance Code Title 14, Chapter 4201, Subchapter A, Section 4201.002 (13) defines "utilization review" as including a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system of prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. This term does not include a review in response to an elective request for clarification of coverage; therefore be it

RESOLVED, That the Texas Medical Association work to align the Texas Occupations Code, Texas Insurance Code, and Texas Administrative Code with clear verbiage that medical necessity decisions are the practice of medicine and can only be performed by a physician with an active license in the state of Texas; and be it further

RESOLVED, That the Texas Medical Association work to align the Texas Occupations Code, Texas Insurance Code, and Texas Administrative Code with clear verbiage requiring that those making peer-to-peer medical necessity decisions be in the same or similar specialty as the treating physician seeking authorization.

Related TMA Policy:

145.024 Medical Decision Makers Licensed in Texas: The Texas Medical Association will (1) support legislation that would amend the Texas Insurance Code to require utilization review agents to be supervised by physicians licensed to practice medicine in the State of Texas and all denials of care based on medical necessity to be made by physicians licensed to practice medicine in the State of Texas and in the same or similar specialty as the treating physician seeking authorization of medical care; and (2) work to amend the Medical Practice Act to clearly include the supervision of persons performing precertification or preauthorization based on medical necessity as the practice of medicine; and include any denial of precertification or preauthorization of medical services based on a determination of medical necessity as the practice of medicine (Amended CL Rep. 1-A-08; amended CSE Rep. 5-A-16).

160.017 Utilization Review: The Texas Medical Association will pursue legislation to ensure that adverse utilization review determinations be made only by physicians who are fully licensed by the Texas Medical Board and monitor proposed legislation to maintain the Texas Medical Board's current authority to enforce the Medical Practice Act in regard to utilization review decisions (CL/CSE Rep. 2-A-09).

225.019 Criteria for Physicians Conducting Peer Review: The Texas Medical Association advocates that physicians who conduct review for health care decisions in Texas should (1) be in an active practice; (2) possess a nonrestricted license to practice in Texas; and (3) be experienced in the procedures or treatment under review. (For example, not all orthopedic surgeons perform spinal surgery.) (Res. 410-A-11).

265.005 Clinical Competence: Quality, appropriateness, and necessity of medical decisions are clinical decisions to be based on clinical data judged by clinically competent persons. In addition, the Texas Medical Association supports legislation and regulations which stipulate that only persons with demonstrable clinical competence for the clinical decisions under review may make the review decisions concerning quality, appropriateness, and/or medical necessity of care related to a specific patient. In addition, TMA supports legislation and regulations requiring any managed care plan wishing to deny coverage or alter a clinical decision for care based on quality, appropriateness, and/or necessity of that care may do so only through clinically competent peer review of all pertinent clinical data (Substitute Res. 28AA, p 182C, A-94; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

265.010 Medical Care Guidelines: The Texas Medical Association opposes the use of so-called medical care guidelines (including, but not limited to, those published by Milliman & Robertson) that are based on economic data rather than evidence-based, scientifically sound medical data (Res. 402-A-00; reaffirmed CSE Rep. 1-A-10).

265.018 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.[2]

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).

[1]TMA's description of evidence-based medicine substantially reflects the work and definition as outlined by Sackett, David L., Sharon E. Straus, W. Scott Richardson, et al. Evidence-Based Medicine: How to Practice & Teach EBM. 2nd edition. London, England: Churchill Livingstone, 2000.

[2] AACVPR/ACC/AHA 2007 Performance Measures on Cardiac Rehabilitation for Referral to and Delivery of Cardiac Rehabilitation/Secondary Prevention Services. Circulation 2007;116;1611-1642.

Related TMA Board of Councilors Current Opinions:

MEDICAL NECESSITY. The determination of medical necessity is the practice of medicine; it is not a benefit determination. Whether or not a proposed treatment is medically necessary should be decided in a manner consistent with generally accepted standards of medical practice that a prudent physician would provide to a patient for the purposes of preventing, diagnosing or treating an illness, injury, disease or its symptoms. This is true even if the physician making the medical necessity determination is making those decisions on behalf of a managed care organization. That physician must not permit financial mechanisms to interfere with his/her determination as to whether a treatment is medically necessary. Although the physician may take cost considerations into account, the physician may not refuse to approve the medical necessity of a treatment simply based on cost, and must approve the treatment if it is clearly more therapeutically effective than other treatment options that may be covered under the plan, even if those treatment options are less expensive than their more costly counterpart.

UTILIZATION REVIEW. The physician who performs prospective and/or concurrent utilization review is obligated to review the request for treatment with the same standard of care as would be required by the profession in the community in which the patient is being treated.

MEDICAL DIRECTORS. Simply because a physician is not providing direct patient care does not mean that the physician is not practicing medicine or obligated to adhere to the principles of medical

ethics. Whenever physicians employ professional knowledge and values gained through medical training and practice, and in so doing affect individual or group patient care, they are functioning within the professional sphere of physicians and must uphold ethical obligations. This is true not only if the physician is making determinations of medical necessity or coverage, but also if the physician is involved in developing a health plan's general policies that affect patient care, e.g., utilization guidelines.

Related AMA Policy:

Definitions of "Screening" and "Medical Necessity" H-320.953

(1) Our AMA defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.

(2) Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word screening in the term "medical screening examination"; "The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist."

(3) Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

(4) Our AMA incorporates its definition of "medical necessity" in relevant AMA advocacy documents, including its "Model Managed Care Services Agreement." Usage of the term "medical necessity" must be consistent between the medical profession and the insurance industry. Carrier denials for non-covered services should state so explicitly and not confound this with a determination of lack of "medical necessity".

(5) Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(6) Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(7) Our AMA advocates that determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided.

(8) Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations.

Medical Necessity Determinations H-320.995

(1) Our AMA urges: (a) health insurance carriers and government health care financing agencies to rely on appropriate medical peer review programs for adjudication and resolution of all matters concerning quality or utilization of medical services requiring professional judgment, and (b) that peer review programs have as their goal both improved quality of care and more efficient delivery of medical service.

(2) Our AMA urges health insurance carriers, government financing agencies, physicians and medical societies to explore ways of improving communications, such as the following: (a) In furtherance of past Association recommendations that policyholders be thoroughly and clearly informed as to the extent of their coverage, more detailed information explaining the "medical necessity" exclusion should be provided, especially when the exclusion refers more to the site of the service than to the service itself. (b) Insurers should develop formal protocols as to their methodology for determining "medical necessity," including distinctions between those instances where in-house medical expertise is considered sufficient and those where outside consultation is considered necessary; (c) Third party methodologies for determining "medical necessity" should be made available to medical societies and to individual physicians, as well as listings of those specific situations (such as the ordering of either experimental or outdated procedures or questionable hospital admissions) where additional data may be required; (d) In "medical necessity" decisions where the determination may be modified by additional medical evidence, there should be an opportunity for the treating physician to provide such evidence before a final decision not to pay is made.

Medical Necessity and Utilization Review H-320.942
Our AMA supports efforts to: (1) ensure medical necessity and utilization review decisions are based on established and evidence-based clinical criteria to promote the most clinically appropriate care; and (2) ensure that medical necessity and utilization review decisions are based on assessment of preoperative symptomatology for macromastia without requirements for weight or volume resected during breast reduction surgery.

Medical Necessity Determinations under Medicare D-335.994
Our AMA will urge the Centers for Medicare and Medicaid Services and Congress that medical necessity denials within the Medicare program be reviewed by a physician of the same specialty and licensed in the same state.

Utilization Review by Physicians H-320.973
1. It is the policy of the AMA to urge its constituent medical associations to (a) seek the enactment of legislation requiring that utilization review for insurers shall be conducted by physicians licensed by the state in which they are doing the review; and (b) seek enactment of legislation that would require all agencies or groups doing utilization review to be registered with the appropriate health regulatory agency of the state in which they are doing review and to have an appropriately staffed office located in the state in which they are doing the review.
2. Our AMA will continue to work with state medical associations to monitor utilization management policy to ensure that hospital admissions are reviewed by appropriately qualified physicians and promote related AMA model legislation.

Sources:
1. Texas Occupations Code, Title 3 Health Professions, Subtitle B Physicians, Chapter 151 General Provision, Subchapter A General Provisions, Section 151.002(13): Sec. 151.002. DEFINITIONS. (a) In this subtitle: (13) "Practicing medicine" means the diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method, or the attempt to effect cures of those conditions, by a person who: (A) publicly professes to be a physician or surgeon; or (B) directly or indirectly charges money or other compensation for those services.

2. Texas Insurance Code, Title 14 Utilization Review and Independent Review, Chapter 4201 Utilization Review Agents, Subchapter A General Provisions, Section 4201.002(1): 4201.002. DEFINITIONS. In this chapter: (1) "Adverse determination" means a determination by a utilization

review agent that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational.

3. Texas Insurance Code, Title 14 Utilization Review and Independent Review, Chapter 4201 Utilization Review Agents, Subchapter A General Provisions, Section 4201.002(14): Sec. 4201.002. DEFINITIONS. In this chapter: (14) "Utilization review agent" means an entity that conducts utilization review for: (A) an employer with employees in this state who are covered under a health benefit plan or health insurance policy; (B) a payor; or (C) an administrator holding a certificate of authority under Chapter 4151.

4. Texas Insurance Code, Title14 Utilization Review and Independent Review, Chapter 4201 Utilization Review Agents, Subchapter A General Provisions, Section 4201.002(13): Sec. 4201.002. DEFINITIONS. In this chapter: (13) "Utilization review" includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.

Distributed at Meeting

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 408
A-18

Subject: Protecting the Prudent Layperson Standard

Introduced by: Carrie de Moor, MD
Collin-Fannin County Medical Society
Nueces County Medical Society
Heidi Knowles, MD, Texas College of Emergency Physicians

Referred to: Reference Committee on Socioeconomics

Whereas, On or about April 18, 2018, Blue Cross and Blue Shield of Texas stated its intent to begin retroactive denial of coverage for HMO members seeking emergency care when the final diagnosis does not prove to be life threatening, beginning June 4, 2018; and

Whereas, Blue Cross and Blue Shield of Texas, Anthem Blue Cross Blue Shield, and other insurers throughout Texas and nationwide have attempted to decrease emergency department utilization by means of financial penalty for patients seeking unanticipated, unscheduled care; and

Whereas, "Emergency care" is defined in Texas Insurance Code Section 843.002(7) as "healthcare services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain"; and

Whereas, The "prudent layperson" standard is an important legal protection for patients that guarantees coverage for emergency care by their health plan, and is defined in Texas Insurance Code Section 843.002(7) as, "a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could: (A) place the individual's health in serious jeopardy; (B) result in serious impairment to bodily functions; (C) result in serious dysfunction of a bodily organ or part; (D) result in serious disfigurement; (E) for a pregnant woman, result in serious jeopardy to the health of the fetus"; and

Whereas, The Texas Medical Association is committed to ensuring that patients not be dissuaded from seeking needed emergency care in situations where they believe their health is at risk; therefore be it

RESOLVED, That the Texas Medical Association adopt the following principles related to unanticipated, unscheduled out-of-network care:

Unanticipated, Unscheduled Out-of-Network Care: Patients who seek emergency care should be protected under the "prudent layperson" standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

Patients must not be financially penalized for receiving unanticipated, unscheduled care from an out-of-network physician or provider.

Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to physician specialties. Texas Department of Insurance should enforce such standards through active regulation of health insurance company plans.

Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments, and other out-of-pocket costs that enrollees may incur.

Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standard should pay out-of-network physicians and providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a physician or provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or physicians and providers and maintained by a nonprofit organization. The nonprofit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan, or health management organization.

Medical necessity review of emergency services must be performed by a board-certified emergency medicine physician licensed in Texas and not affiliated with an insurer, a municipal cooperative health benefit plan, health management organization, or the physician or provider or facility in question.

Health plans should readily disclose their pricing methodologies for payment for both in-network and out-of-network emergency care to health plan members, employers, legislators, physicians and providers, and facilities in a transparent and easily accessible manner; and be it further

RESOLVED, That TMA develop model state legislation addressing the coverage of and payment for unanticipated, unscheduled out-of-network care and strengthening of the prudent layperson standard; and be it further

RESOLVED, That TMA actively oppose any health plan or other payer policy that dissuades patients from seeking needed emergency care in situation where they believe their health is at risk.

Related TMA Policy:

145.024 Medical Decision Makers Licensed in Texas: The Texas Medical Association will (1) support legislation that would amend the Texas Insurance Code to require utilization review agents to be supervised by physicians licensed to practice medicine in the State of Texas and all denials of care based on medical necessity to be made by physicians licensed to practice medicine in the State of Texas and in the same or similar specialty as the treating physician seeking authorization of medical care; and (2) work to amend the Medical Practice Act to clearly include the supervision of persons performing precertification or preauthorization based on medical necessity as the practice of medicine; and include any denial of precertification or preauthorization of medical services based on a determination of medical necessity as the practice of medicine (Amended CL Rep. 1-A-08; amended CSE Rep. 5-A-16).

145.037 Out-Of-Network Billing: The Texas Medical Association will 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 (BOT Rep. 12-A-16).

180.032 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.

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; amended CSE Rep. 7-A-17).

180.020 Managed Care Education: The Texas Medical Association will pursue initiatives, independently and in collaboration with other stakeholders as appropriate, to educate patients and employers about the most effective ways to use managed care benefit packages (Council on Health Facilities, p 73, A-95; amended CSE Rep. 1-A-05; reaffirmed CSE Rep. 1-A-15).

160.017 Utilization Review: The Texas Medical Association will pursue legislation to ensure that adverse utilization review determinations be made only by physicians who are fully licensed by the Texas Medical Board and monitor proposed legislation to maintain the Texas Medical Board's current authority to enforce the Medical Practice Act in regard to utilization review decisions (CL/CSE Rep. 2-A-09).

145.025 Out-of-Network Payments: The Texas Medical Association supports legislation for clear and transparent health insurance company language so that prudent lay persons would know their financial responsibility when receiving care out of network (Res. 401-A-09).

180.004 Managed Care Antitrust: State and federal antitrust laws should apply equally to health maintenance organizations, preferred provider organizations, and physician/hospital organizations to assure a fair framework for fair competition; that fair market practices should be required of HMOs, PPOs, and PHOs, and of all managed care organizations; that fair market practices should include basing physician credentialing quality assurance and utilization review decisions by managed care organizations on quality considerations; and that quality considerations may include physician profiling for educational purposes or to target chart review for determining medical necessity, prudent, or wasteful practices, utilizing peer review and due process (CSE, p 145, A-93; reaffirmed CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13).

130.019 Emergency Medical Treatment and Active Labor Act: The Texas Medical Association supports requirements for health care payment plans to provide fair payment for services rendered under the Emergency Medical Treatment and Active Labor Act mandate and opposes efforts to limit or restrict balance billing of patients for out-of-network physician services (Amended Res. 402-A-09).

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).

130.016 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; reaffirmed CSE Rep. 7-A-17).

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).

100.026 Emergency Department On-Call Physicians: The Texas Medical Association will work with health care organizations and governmental agencies to ensure adequate emergency department on-call specialist access; maintain current liability protection for treatment of emergency medical conditions; and ensure appropriate physician compensation, given existing and special hospital funding for emergency services (Amended Res. 206-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).

195.015 Medicare Nonpayment for Emergency Office Care: Medicare should reimburse for CPT Codes that offer additional reimbursement beyond the billed E&M code for emergency office care on Sundays and holidays (Res. 28U, p 179, A-94; reaffirmed CSE Rep. 3-A-04; amended CSE Rep. 2-A-14).

240.004 Medicare Reimbursement for Emergencies: The Texas Medical Association supports reversal of Medicare's policy of reimbursing for emergency visits only if patients are seen in an emergency room setting (Res. 27C, p 165, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

235.023 Reimbursement for Uncompensated Services to the Uninsured or Underinsured: The Texas Medical Association supports legislative relief, such as tax code modifications, financial compensation, and liability relief, for physicians who provide uncompensated services to uninsured or underinsured patients in compliance with governmental mandates (Res. 210-I-01; reaffirmed CSE Rep. 8-A-11).

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) 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; reaffirmed BOT Rep. 12-A-16).

190.023 Policy Principles for Medicaid and CHIP Legislative Initiatives (abbreviated): 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….
(AHCM-MAC Rep. 1-1-04; amended SC-MCU Rep. 1-A-15).

Related AMA Policy:
Out-of-Network Care H-285.904
Our AMA adopts the following principles related to unanticipated out-of-network care:

1. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

2. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

3. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

4. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

5. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

6. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

7. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

8. Mediation should be permitted in those instances where a physician's unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.

Access to Emergency Services H-130.970

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:

(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

(C) All health plans should be prohibited from requiring prior authorization for emergency services.

(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.

(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third party payer whether it is retrospectively determined that an emergency existed or not.

(G) States should be encouraged to enact legislation holding health plans and third party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.

(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.

(I) In instances in which no private or public third party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the "prudent layperson" standard of determining when to seek emergency care.