Council on Health of the Public

Thursday, November 13, 2025
2:30 – 5 p.m.
Location: Renaissance Dallas Addison Hotel, Colonnade room
Zoom information:
https://us02web.zoom.us/j/87119317169?pwd=EJmonXXa3Gxa5VC6g8NOTJioRh7dw1.1
Meeting ID: 871 1931 7169
Passcode: 488344

AGENDA

2:30	Call to order by Chair Li-Yu Mitchell, MD, and introductions
2:37	Approval of report from April 4, 2025
2:40	Announcements • Reception tonight at 6 p.m., followed by the Member Assembly with Council Forums at 7 p.m., both take place in the Crystal Ballroom. • Free CME Workshop on Obesity – Practice Pearls in Obesity Management: A Case-Based Discussion, Saturday at 2 p.m., led by Richel Avery, MD
2:43	Matthew Dufrene, MBA, Vice President of Texas Health, will discuss Fort Worth's Blue Zones Project
3:05	TAFP member Micah Nishigaki, MD, will discuss climate/environmental health
3:15	TAFP member Eduardo Sanchez, MD, MPH, will discuss a possible resolution to AAFP on blood pressure
3:30	TAFP member Allison Tobola, MD, will discuss a possible resolution to AAFP on organ donation
3:45	Discussion on results from council's public health priority survey of TAFP members
4:15	Other business
4:30	Adjourn

Samantha White and Jessica Miley are the staff liaisons for this council.

COUNCIL ON HEALTH OF THE PUBLIC REPORT

Author: Samantha White
Meeting date: April 4, 2025

The following members attended the meeting in person: Li-Yu Mitchell, Sarah Ashitey, Richel Avery, Priti Mody-Bailey, Rebecca Hart, Karen Smith, Astrud Villareal, Judy Kim, Joaquin Villegas, Austin Plumlee, Susan Overstreet, Shadi Edalati, and Kimberly Ellis-Garris.

The following members attended the meeting on Zoom: Vyas Sarabu, Sarah Toates, James Mobley, Victoria Udezi, and Deepalakshmi Rajakrishnan.

The following staff and guests attended the meeting in person: Samantha White (staff), Jessica Miley (staff), Tom Banning (staff), Rashmi Rode, Dwane Broussard, Terrance Hines, and Emily Briggs.

MINUTES

1. The meeting was called to order by Li-Yu Mitchell, MD, chair.
2. The council report from November 7, 2024 was approved.
3. Council member Richel Avery, MD, gave an update on the Task Force on Obesity's latest work and told the council about future opportunities for the task force.
4. Mitchell shared recent projects completed by the council.
    a. The council is once again surveying all TAFP members on their current public health priorities: www.surveymonkey.com/r/68TVJ65
    b. TAFP's immunization toolkit: www.tafp.org/healthy-practice/immunization-resources
    c. The high school wellness graduation cord project is now available to TAFP members to participate in: www.tafp.org/healthy-practice/wellness-grad-cords
5. TAFP CEO Tom Banning gave a legislative update.
6. The meeting was adjourned.

The climate crisis poses a dire threat to nearly every aspect of our health and the planet.[1] Much of climate change is driven by human activities and our dependence on fossil fuels (for transportation, energy production, or agriculture), which release greenhouse gases (GHG) like carbon dioxide and methane, as well as air pollutants such as $PM_{2.5}$, lead, and acid gases.[2, 3] These emissions contribute to global warming and trigger the cascading effects of climate change that we are witnessing in our lifetimes—effects that have serious consequences for human health.

In recent decades, we have seen an increase in extreme weather events, including floods, wildfires, droughts, and hurricanes. These often dismantle healthcare systems, leading to delays in care that can worsen chronic illnesses or disrupt essential treatments like dialysis or cancer care.[4, 5] Wildfires contribute heavily to air pollution, worsening air quality and exacerbating respiratory conditions such as asthma and COPD.[6] Increased rainfall and flooding can introduce sewage and other harmful contaminants into food and water supplies, posing serious risks to human health and environmental safety.[7]

Climate change causes extreme heat, which has been linked to common conditions Family Medicine physicians commonly see in their practice, such as acute congestive heart failure and cardiac arrhythmias; COPD and asthma exacerbations; preterm birth or congenital heart defects; heat rashes and seborrheic dermatitis; worsening mental illness like depression and schizophrenia; and acute renal failure and nephrolithiasis.[8, 9] Additionally, increased atmospheric carbon dioxide from GHG emissions has been linked to reduced levels of micronutrients such as zinc, iron, and protein in staple crops.[10] These nutritional losses could worsen undernutrition (wasting and stunting), overnutrition (overweight and obesity), and micronutrient deficiencies.

Climate change also disproportionately harms disadvantaged communities.[11, 12] For example, lower and middle income countries contribute less to GHG emissions and climate change, yet are the regions that face more climate burdens compared to countries that contribute more to climate change.[13] Additionally, many of these regions do not have the resources or infrastructure to protect them from floods or extreme heat, or ways to mitigate harms from air pollution.

Thus, as stewards of public and preventative health, it's imperative that Family Medicine physicians are knowledgeable about climate health. The consequences of climate change are insidious, infiltrating nearly every facet of a patient's care (see diagram below for other highlights). I urge TAFP to make climate and environmental health a focus in our mission to "promote the health of all Texans" and "advancing the specialty of Family Medicine." One way we can do this is to provide comprehensive CME on environmental and climate medicine, including climate health impacts, environmental justice and health equity, and how physicians can be advocates for initiatives or policies to fight for environmental equity and health for all. I am eager to further discuss what this could look like, as well as other ideas with how TAFP can spearhead the discussion on climate health. Our planet's health is our health, and we must do what we can to protect our earth and our communities we were tasked to care for.

Table 1.2. Climate Change Is Already Affecting All US Regions and Will Continue to Have Impacts in the Near Term

The table shows three climate impacts of significant concern to each US region between now and 2030. Icons indicate general categories of impacts: infrastructure, water supply, health and well-being, food security, economy, livelihoods and heritage, and ecosystems. More information can be found in the regional chapters (Chs. 21–30).

Northeast

- Extreme weather events damage critical infrastructure. {21.1}
- Warming temperatures shift distributions of coastal and marine species and habitats. {21.2}
- Extreme heat and flooding disproportionately impact overburdened communities. {21.3}

Southeast

- Sea level rise and coastal flooding harm rapidly growing communities. {22.1}
- Extreme heat threatens human health, especially stressing urban communities. {22.2}
- Heavy rain and longer dry spells reduce water supply and access. {22.4}

US Caribbean

- Agricultural losses, especially from tropical cyclones, threaten food security. {23.1}
- Severe drought leads to large agricultural and economic losses. {23.3}
- Rising temperatures increase mortality and power demand; hurricanes and storms stress power grids. {23.2, 23.4}

Midwest

- Rising temperatures and extreme events threaten livelihoods and trades. {24.2}
- Extreme weather events harm public health. {24.3}
- Rising temperatures and extreme rainfall damage buildings, homes, and businesses. {24.4}

Above: Other examples of how climate change can impact patient's health, including social determinants of health (SDoH). Fifth National Climate Assessment.[14]

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2) United States Environmental Protection Agency. "Overview of Greenhouse Gases." *US EPA*, 16 Jan. 2025, www.epa.gov/ghgemissions/overview-greenhouse-gases. Accessed 20 Sept. 2025.

3) EPA. "Criteria Air Pollutants | US EPA." *US EPA*, 29 Jan. 2019, www.epa.gov/criteria-air-pollutants. Accessed 20 Sept. 2025.

4) Waddell, Samantha L., et al. "Perspectives on the Health Effects of Hurricanes: A Review and Challenges." *International Journal of Environmental Research and Public Health*, vol. 18, no. 5, 9 Mar. 2021, p. 2756, www.ncbi.nlm.nih.gov/pmc/articles/PMC7967478/, https://doi.org/10.3390/ijerph18052756.

5) Abebe, Yared Abayneh, et al. "Flood Impacts on Healthcare Facilities and Disaster Preparedness – a Systematic Review." *International Journal of Disaster Risk Reduction*, vol. 119, 24 Feb. 2025, p. 105340, www.sciencedirect.com/science/article/pii/S2212420925001645, https://doi.org/10.1016/j.ijdrr.2025.105340.6)

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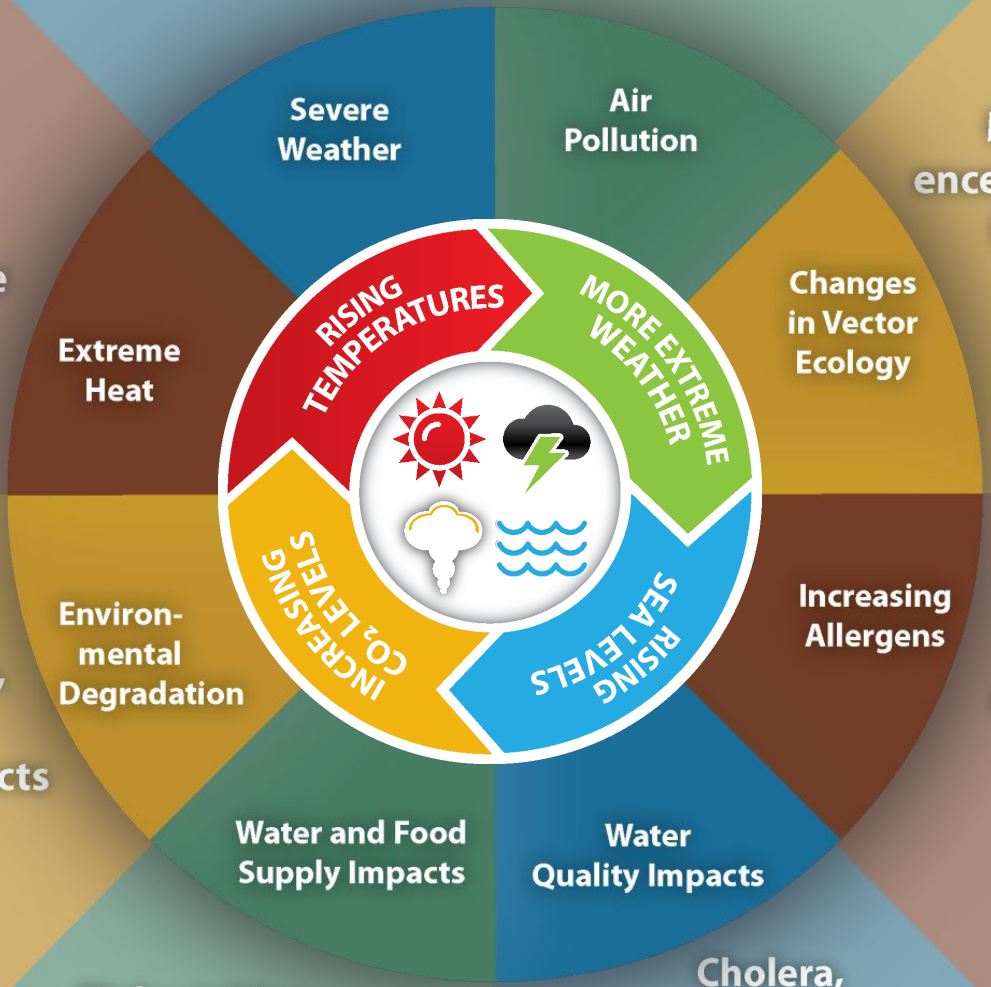
Impact of Climate Change on Human Health



Injuries, fatalities, mental health impacts

Asthma, cardiovascular disease

Heat-related illness and death, cardiovascular failure

Malaria, dengue, encephalitis, hantavirus, Rift Valley fever, Lyme disease, chikungunya, West Nile virus

Forced migration, civil conflict, mental health impacts

Respiratory allergies, asthma

Malnutrition, diarrheal disease

Cholera, cryptosporidiosis, campylobacter, leptospirosis, harmful algal blooms

Affirming the Dead Donor Rule as a Safeguard in Ethical Organ Donation

Whereas, the Dead Donor Rule (DDR) holds that vital organs may only be procured from donors who have been declared dead by accepted medical standards, and that the act of organ procurement must not be the cause of the donor's death;

Whereas, the DDR reflects a longstanding ethical commitment to protect vulnerable patients, uphold human dignity, and ensure that organ donation occurs only within clearly defined boundaries that preserve public trust and the integrity of medicine;

Whereas, while there is ongoing debate regarding how death should be defined and proposals to revise the Uniform Determination of Death Act (UDDA), this resolution does not take a position on that debate; it affirms only that death—however defined—must be determined before the removal of vital organs;

Whereas, proposals have emerged suggesting that individuals not yet legally or medically dead should be permitted to donate vital organs based on prior consent; while grounded in autonomy, such proposals raise profound ethical concerns, including the risk of undermining informed consent, pressuring vulnerable individuals or families, and eroding public confidence in the organ transplantation system;

Whereas, the ethical distinction between allowing death to occur (such as through the withdrawal of non-beneficial or disproportionate treatment) and actively causing death by the procurement of vital organs from a living patient is foundational to medical ethics; upholding this distinction is essential to transparency and informed consent;

Whereas, public trust in organ donation depends on confidence that ethical safeguards prevent even the appearance of compromising patient dignity or hastening death for the benefit of others; protecting vulnerable individuals from being used as a means to an end is essential to maintaining trust and moral integrity in medicine;

Whereas, robust ethical organ donation policies must ensure that all individuals—regardless of their beliefs about end-of-life autonomy—are protected from harm, coercion, and ambiguous practices that may compromise the integrity of medical decision-making;

Therefore, be it resolved, that the AAFP affirms its support for the Dead Donor Rule as a foundational ethical safeguard in organ donation and transplantation: vital organs may only be procured after death has been declared, and the act of procurement must never be the cause of death—thereby upholding patient dignity, public trust, and the moral integrity of medicine;

Be it further resolved, that the AAFP, while acknowledging ongoing debates about the definition of death and potential revisions to the Uniform Determination of Death Act, affirms that death—however legally and medically defined—must remain the threshold for vital organ procurement; and opposes any policy or practice permitting the removal of vital organs from individuals not yet declared dead, even with prior consent, due to the risks of exploitation, coercion, erosion of confidence in healthcare integrity, and loss of public trust.

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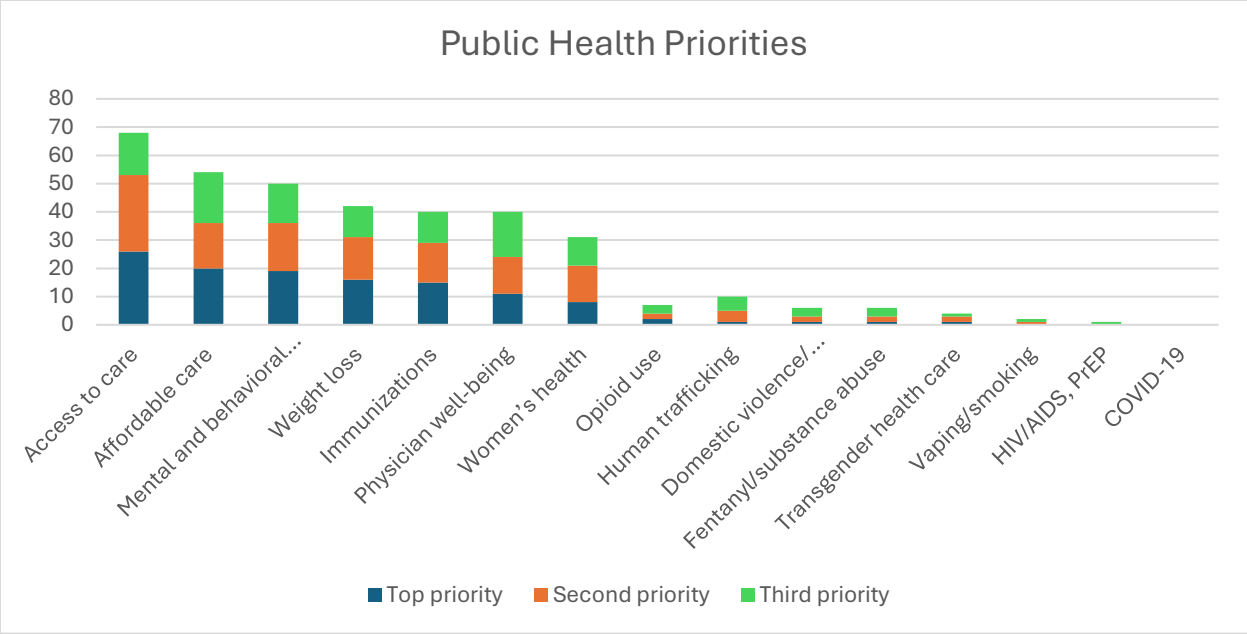

How long have you been in practice?

	Count	%
More than 25 years	51	40%
11 to 15 years	18	14%
5 years or less	17	13%
21 to 25 years	15	12%
6 to 10 years	14	11%
16 to 20 years	14	11%

Which of the following best describes your role in the ownership of your primary clinical practice?

	Count	%
No official ownership stake in your practice (100% employed)	85	67%
Sole owner of your practice	23	18%
Working in one or more practices as an independent contractor	12	9%
Partial owner or shareholder	7	6%

Who is your primary employer?

	Count	%
You (self-employed, majority practice owner, independent contractor)	34	55%
Hospital or health system practice	30	48%
Academic medical center	23	37%
Physician group (single or multispecialty)	17	27%
Federally qualified health center or community health center	7	11%
On-site clinic or organization	4	6%
State or local government (not an academic medical center)	4	6%
Community-based family medicine residency program	3	5%
Insurance company or managed care organization	2	3%
Federal (military, VA, Department of Defense)	1	2%
Locum tenens group or staffing organization	1	2%

Resources from the American Cancer Society, October 2025

The Announcement Approach for Increasing HPV Vaccination: Take these steps to more effectively recommend HPV vaccination. They will save you time and improve patient satisfaction. HPVIQ-flyer-src_edit_Sep2022

HPV Vaccination Evidence Summaries: The ACS National HPV Vaccination Roundtable's Best Practice Task Group has developed a series of short, easy to read documents that present scientific evidence that address clinical, public health, health system policy, and social-system policy questions related to HPV vaccine acceptance. Each summary includes basic findings from research on "What's Known," "What's New," and "What's Next". HPV Vaccination Evidence Summaries - National HPV Vaccination Roundtable

Start HPV Vaccination at Age 9: New research reinforces the recommendation to start offering HPV vaccines at age nine. Read NEW evidence, recently published, on the impact of initiating HPV vaccination at ages 9-10, including population studies, quality improvement projects, brief reports, and commentaries from experts in the field. The collection of 10+ published articles shows the benefits, effectiveness, and acceptability of routinely recommending HPV vaccination for all preteens starting at age nine. There is also an Age 9 Toolkit, a Communication Toolkit, a Why Age 9 Fact Sheet, and many other helpful tools and resources. Start HPV Vaccination at Age 9 - National HPV Vaccination Roundtable

HPV Vaccination Promising Practice Series: The American Cancer Society (ACS) and the ACS National HPV Vaccination Roundtable (HPVRT) are inviting health professionals to learn about the latest evidence-based practices to improve HPV vaccination among adolescents aged 9–13 nationwide. Join us for this informative quarterly series! There are recorded webinars from 2024 as well as an invitation to live 2025 webinars.
HPV Vaccination Promising Practices Series - National HPV Vaccination Roundtable