


5. Committee on Infectious Disease Report 1 – Sunset Policy Review

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


8. Committee on Emergency Services and Trauma Report 1 – Cardiac Arrest as a Reportable Condition

9. Committee on Emergency Services and Trauma Report 2 – Recommendation on Emergency Department Diversion and Saturation Policy


11. Resolution 301 – Access to Direct-acting Antiviral Therapy for Texas Medicaid Beneficiaries Infected With Hepatitis C (Tabled Res 310 2020)

12. Resolution 302 – Advocating for the Improvement of Access to Mental Health Services Among Minority Teens (Tabled Res 311 2021)

13. Resolution 303 – Designating Texas Hospitals as Sensitive Locations (Tabled Res 315 2020)


21. Resolution 311 – Lowering the Legal Age for Minors to Access Contraceptive Services (Tabled Res 328 2020)
22. Resolution 312 – Advocating Against Electronic Nicotine Delivery Systems (ENDS) (Tabled Res 301 2020)
24. Resolution 314 – Promoting Safe and Effective Disposal of Polystyrene Foam Medication Case(s) With or Without Ice Packs
25. Resolution 315 – Possible Upcoming Shortage of Fentanyl and Other Opioid Injections
27. Resolution 317 – Decommissioning Existing and Not Constructing New Wastewater Treatment Plants in or Near Flood Plains and Waterways (Tabled Res 307 2020)
29. Resolution 319 – Support for the Texas-CARES Program (Tabled Res 312 2020)
30. Resolution 320 – Impact of Social Networking Services on the Health of Adolescents
31. Resolution 321 – Restore and Add Funding to Public Health
33. Resolution 323 – Education and Action to Arrest the Effects of Climate Change on Health (Tabled Res 309 2020)
34. Resolution 324 – Required Platelet Products at a Facility in Maternal Levels of Care Designation (Tabled Res 314 2020)

38. Resolution 328 – Outreach and Education in Mixed-Status and Undocumented Communities Regarding Information Gathering and COVID-19 Vaccine Distribution

39. Resolution 329 – In Support of Comprehensive Sexuality Education Reform

40. Resolution 330 – In Support of Reevaluating the Use of Race in Estimated Glomerular Filtration Rate

41. Resolution 331 – Support for Increasing Digital Access

42. Resolution 332 – Opposition to Criminalization of Gender-Affirming Care for Transgender Youth

43. Resolution 333 – Opposition to Sobriety Requirement for Hepatitis C Treatment

44. Resolution 334 – Racism as a Public Health Issue

45. Resolution 335 – Public Health and Health Care Protections While Incarcerated

46. Resolution 336 – Results and Regulation of Freestanding Birthing Centers and at Home Birthing Services (Tabled Res 426 2020)

47. Resolution 337 – Advocating for Evidence-Based Care for Incarcerated Pregnant Women in Texas Correctional Facilities

48. Resolution 338 – Support for Immunization Information System Interjurisdictional Data Exchange

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

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

51. Resolution 341 – Acknowledging Abortion is a Time-Sensitive Medical Procedure

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

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


55. Resolution 345 – TMA Statement on the Health Impact of Racism

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

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

59. Resolution 349 – Reducing Intimate Partner Homicide

60. Resolution 350 – Restricting School Immunization Exemptions to Exemptions for Medical Reasons

61. Resolution 351 – Support of a Statewide Contact Tracing App

62. Resolution 352 – Mental Health Education in Schools


64. Resolution 354 – Addressing Race in Medicine

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

66. Resolution 356 – Support Statewide Planning and Communication for a Vaccine Plan During a Pandemic
Subject: Sunset Policy Review

Presented by: Wendy M. Chung, MD, Chair

Referred to: Reference Committee on Science and Public Health

House of Delegates policies in the association’s Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the council with recommendations for retention, amendment, and deletion.

**155.001 Laboratory Director Requirements:** The Texas Medical Association supports maintaining the existing requirement calling for the position of laboratory director to be filled by a medical doctor for the following reasons: (a) The director of transfusion services and blood banks must deal directly with surgeons, oncologists, hematologists, obstetricians, pediatricians and other medical professionals on clinical issues regarding therapy (i.e., the type, amount and timing of blood transfusions); (b) The director interprets laboratory data for clinicians and advises on the clinical significance of data (i.e., antibodies and coagulation changes); (c) The director must educate medical staff and physicians-in-training in transfusion medicine; (d) The director must do quality assurance not only for the laboratory, but also on utilization and transfusion practices; and (e) The director must relate to operating room practices and the procedures directly related to patient care (i.e., therapeutic apheresis) (Committee on Blood Banking and Blood Transfusion, p 120, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

**260.086 Retire Coal-Fired Power Plants and Replace With Cleaner Energy Sources:** The Texas Medical Association urges the Texas Legislature to establish a statewide energy plan formulated and maintained by an energy planning council, whose goals are to maintain the integrity of the electricity grid; ensure reasonable electricity rates; reduce air, water, and other environmental pollution; and manage water usage in power generation (Res. 202-A-11).

**260.088 United States-Mexico Border Health Commission:** The Texas Medical Association recognizes the many contributions of both the United States-Mexico Border Health Commission and the Border Health Caucus and urges the two TMA-sponsored groups to continue to work together and advance the goals of TMA and organized medicine in Texas and all along the southern border of the United States (Res. 204-A-11).

**Recommendation 1:** Retain.

The council recommends amending these policies as follows:

**260.004 Scalding Hot Water:** Recognizing that water at a temperature of 150 degrees can cause third degree burns in two seconds, water at 140 degrees can cause third degree burns in less than five seconds, and that 21.5 percent of all burns in children are caused by scalding incidents primarily in the home, and that scalds may result in significant morbidity, loss of autonomy, and health care costs for the elderly, the Texas Medical Association recommends that all residential water heaters, including those in older residences, be updated and maintained at
a thermostat setting of no more than 120 degrees Fahrenheit according to International
Plumbing Code 2015 (IPC 2015) adopted and amended by the Texas Industrialized Housing
and Buildings Program. TMA will continue to incorporate into its existing public and
professional education programs information about burns and burn prevention (Res. 27F,

280.003 Science and Education in Public Schools: Considering the goal of improving the public
school system through active participation, and Concerned with the anticipated shortage of
health care professionals and fewer students taking science and math courses, the Texas
Medical Association supports the promotion of science and health education, and
endorses involvement by TMA members within the public school system where possible,
whether through direct mentorship, outreach efforts, or enrichment programs continuation of
outreach efforts to expose students to science and the benefits of a health career. In addition,
TMA encourages its members to work with local school systems to establish advanced
placement and enrichment programs in Science, Technology, Engineering, and Math (STEM)
with special emphasis on encouraging participation of disadvantaged students in these
programs.

Recommendation 2: Retain as amended.

The council recommends deletion of the following policies as they are no longer relevant or the policy
was consolidated with other similar policy:

55.027 Public School Education: With the goal of improving the public school system through
active participation, TMA members are encouraged to become involved with the public
school system in their areas to the degree possible, including mentoring students and joining
in community/school partnership programs, where available. In addition, TMA encourages its
members to work with local school systems to establish advanced placement and enrichment
programs in Science, Technology, Engineering, and Math (STEM) with special emphasis on
encouraging participation of disadvantaged students in these programs (Council on Medical

95.016 Computer Pharmacy Records Used for Marketing Purposes: As a means of protecting
patient privacy, physicians and patients should be allowed to “opt out” of pharmacy plan data
acquisition upon written request, except as otherwise required by law for scheduled or
narcotic drugs. Any specific consent for data accumulation should have specific time and use
restrictions. Data management companies employed by pharmacies and HMO plans should
be prohibited from selling access, direct or indirect, to physician-patient lists for the purposes
of marketing. (Substitute Res. 29P, p 164, I-97; reaffirmed CSA Rep. 2-I-01; reaffirmed

95.020 Breach of Privacy with Patient Prescription Drug Profiles: Confidential quality
assurance/quality initiative prescription drug profiles should not be provided by
pharmaceutical companies to their marketing staff or other unauthorized persons for
marketing purposes. The Texas Medical Association voted to seek legislative controls to
prohibit the use of this patient drug information in the marketing of pharmaceutical
Driving While Using Hand-Held Electronic Communication Devices: The Texas Medical Association firmly stands against the epidemic use of hand-held electronic communication devices while driving (Res. 201-A-11).

Recommendation 3: Delete.
Resolution 303 by the Dallas County Medical Society was presented at the 2019 House of Delegates in support of improvements in medical clearance policies for patients with traumatic brain injury (TBI). The resolution called for the Texas Medical Association to reaffirm its firearm policy on Texas gun laws and regulations relating to medical need and public safety. Other recommendations called for TMA legislative advocacy for:

- Amending Texas law to clearly prohibit symptomatic TBI patients from obtaining or retaining a license to carry a firearm until medical clearance;
- State legislation to expand both the medical clearance requirements and the firearm purchasing restrictions in Texas’ license-to-carry statute;
- Legislation to promote and emphasize the need for physician reporting to the Texas Medical Advisory Board all patients with prohibitive conditions, including symptomatic TBI patients; and
- Expanding the role of the Medical Advisory Board to include oversight of impaired persons with gun licenses and increasing physician awareness of the board and on required reporting.

Finally, the resolution called for the adoption of new TMA policy related to TBI and access to firearms and taking the policy to the American Medical Association for consideration.

The author of the resolution reported that each day up to 6,000 people in the U.S. sustain a traumatic brain injury and that those with a TBI are twice as likely to commit suicide, including veterans. Also, a large proportion of people with moderate to severe TBI are subsequently diagnosed with a psychiatric disorder. And while TMA has studied and developed policy on firearm-related injuries and fatalities, there has not been a focus on the impact of cognitive or mental deficits associated with TBI and access to firearms.

Resolution 303 was referred to the Council on Science and Public Health, the Council on Legislation, and the Office of General Counsel for study.

**Traumatic Brain Injury**

The Centers for Disease Control and Prevention (CDC) reports it is difficult to confirm the incidence and prevalence of TBI but notes that based on health facility-related data, the most common causes of TBI are falls, motor vehicle accidents, and strikes or blows to the head – often associated with a sport injury. A blow or bump to a person’s head is a force to the brain that can cause temporary or permanent physical damage including cognitive and behavioral impairments. Secondary disorders are not uncommon such as the development of attention deficit disorder in children following an acquired brain injury.

- CDC states that in the U.S. those most likely to have TBI are children aged 0-4 years and adolescents aged 15-19 years. Those older than 75 years are most likely to have an emergency department visit or to be hospitalized for a TBI.
The Texas Brain Injury Alliance reports that more than 381,000 Texans live with TBI-related disability, and there are more than 144,000 new TBI cases in Texas each year. Most of those with TBI are identified as having a mild TBI with symptoms such as loss of consciousness, memory loss, an inability to concentrate, mood changes, fatigue, or anxiety. Such symptoms are generally thought to be resolved within three months after the trauma. However, a recent meta-study notes that about half of those with a single mild TBI can have long-term cognitive impairment.

Federal and State Law on Firearm Possession/Purchase

**Federal.** The federal government defines a firearm (18 USC §921[3]) as a weapon that can expel a projectile by an explosive or is or can be converted to expel a projectile. Possession or receipt of a firearm is prohibited under federal law (18 USC §92[g] and [n]) by a person who is a felon (or awaiting trial on a felony charge); is a drug user or addict; has a prior conviction for domestic assault or is subject to a domestic protective order; is a fugitive or is in the U.S. illegally; or was dishonorably discharged from the U.S. military; or people with a history of certain mental health conditions (e.g., committed to a mental health institution or declared to have a severe mental illness).

**Texas.** Subchapter H of Government Code 411, Section 172, outlines Texas law on licensure for the carrying of a handgun. State law allows handgun licensure for those who are legal residents of Texas (six months prior to application), and:

- Without a conviction of a felony and not charged with a Class A or B misdemeanor or another offense under the state Penal Code (§42.01), or of a felony under an information on indictment;
- Not a fugitive from justice or chemically dependent, and capable of exercising sound judgment on proper handgun use and storage; and
- Not a respondent under a protective order and not found delinquent in child support payments or other tax payment and also qualified under federal law to purchase a handgun.

In Section 172(d) of the Government Code, “incapacity to exercise sound judgment to possess and store a handgun” refers to a person who has been diagnosed by a physician to have a psychiatric disorder that can cause impairment in judgment, perception, impulse control, or intellectual ability.

- Evidence of a psychiatric disorder includes involuntary and voluntary psychiatric hospitalization; inpatient or residential treatment in the prior five-year period for substance use disorder; diagnosis that the person is dependent on alcohol, a controlled substance, or another similar substance; or diagnosis of a history of certain psychiatric disorders (schizophrenia or delusional disorder; bipolar disorder, chronic dementia, intermittent explosive disorder, or an antisocial personal disorder).
- A licensed physician whose primary practice is psychiatry may provide information that the person is in remission or is not likely to develop a psychiatric disorder.
- Those under age 21 cannot purchase handguns, but state law provides an exception for adults aged 18-20 years if they are a member or veteran of the U.S. Armed Forces or were discharged under honorable conditions and otherwise would be eligible to purchase a handgun under federal law.

Texas follows federal law on the purchase of firearms, which applies only to federally licensed firearm vendors. Texas statute defines a firearm and outlines the unlawful carry of weapons where weapons are prohibited as well as the licensure for concealed carry (licensure is required in Texas to carry a handgun). The Texas Department of Public Safety (DPS) is responsible for the licensure of individuals to carry a concealed handgun and those who want a license to drive a vehicle in Texas. The state’s rules are outlined in the state administrative code.
Medical Advisory Boards

Most states (37 states in 2017) have a medical advisory board, although the responsibilities of these entities can vary by state. The Texas Legislature established this state’s board to support DPS’ licensure for those seeking a license to drive a motor vehicle or a school bus, or to carry a concealed handgun. DPS seeks a medical review of those who already have or are applying for licensure who self-report (e.g., when they apply for a license and identify a particular health condition or limitation); are reported by others including physicians; or are tagged due to an event associated with law enforcement (e.g., a penalty for a motor vehicle accident when driving under the influence). The DPS referral triggers a medical review by the Medical Advisory Board.

The Texas Department of State Health Services (DSHS) administers and supports the board, whose members are physicians of specialties as set in state statute (board certified in internal medicine, physical medicine, neurology, psychiatry, ophthalmology, or optometry) and are recommended by DSHS and TMA or the Texas Optometric Association. A DSHS report for July 2018-August 2019 indicates that 7,501 people were referred to the Medical Advisory Board in this period for medical clearance review. Almost 97% of these were for the review of someone seeking a driver’s license, 2.5% were for someone applying for a concealed handgun license, and the remaining were for a license as school bus driver. DSHS indicates there are insufficient appointments to the advisory board to meet the above demand. Mandatory reporting would dramatically escalate this shortage.

Finally, DPS is solely responsible for the licensure for a concealed handgun, driver’s license, or school bus driver’s license. The Medical Advisory Board members conduct an independent record review and offer their opinion on the person’s capacity to drive or safely possess a concealed handgun. Per state statute, physician members of the board cannot be held liable for providing information or their professional opinion. However, participating physicians are volunteers and currently must travel to Austin for meetings, for which they receive nominal compensation. Figure 1 below shows the process the Texas board follows for its review of Texas residents referred by DPS.

Physician Reporting of Patients

While there is generally not a requirement to report, all states allow physicians to report to law enforcement or public safety officials a patient they are treating if they believe the patient may pose a risk to self or to others. In Texas, this exception to patient-physician confidentiality is outlined in Health and Safety Code, Section, 12.096, which allows any licensed physician to inform DPS or the Medical Advisory Board in writing or orally of a patient 15 years or older whom the physician has diagnosed as having a disorder or disability as noted in the DPS requirements (see also TMA Board of Councilors Current Opinions, Impaired Drivers).

The laws also address physician reporting in Texas:

- Chapter 92 of the Texas Health and Safety Code on injury prevention and control requires the reporting of certain injuries by physicians, medical examiners, hospitals, and justices of the peace. It calls for mandatory reporting of traumatic brain injuries, defined as an acquired injury to the brain including injuries caused by anoxia but does not include brain dysfunction associated with birth trauma or congenital or degenerative disorders. These injuries are reportable to the Texas Brain Injury Reporting Registry supported by DSHS.
- The Texas Mental Health Code allows mental health professionals to disclose confidential patient information only to medical or law enforcement personnel if they believe there is a high probability that the patient or others are at risk of immediate mental or emotional injury. Texas law prohibits the sharing of similar information with a patient’s family or known loved ones.
Figure 1. Medical Advisory Board for Driver Licensing and Evaluation for Concealed Handgun

**Self Referral**
- Concealed handgun application re: psych. history
- Driver licensing application re: medical history

**Law Enforcement Referral**
- Incident reports to DPS Concealed Handgun Section
- Officer reports to DPS Driver Improvement Bureau

**Physician Referral**
- Voluntary report to DPS Driver Improvement Bureau
- EMS personnel report to physician

DPS clerks screen reports and refer to Texas Dept of Health MAB section, according to Govt. Code §411.172 or 37 TAC §15.58 guidelines

Medical history forms sent to licensee/applicant

MAB staff prepares cases for MAB physicians

MAB physicians review cases and write opinions

MAB physician opinions sent to DPS

**DPS Driver Licensing Office Referral**
- Driving record
- Observed or admitted medical conditions
The National Traffic and Safety Administration notes several states have mandated physician reporting of certain impaired drivers, e.g. those with specific conditions: epilepsy, dementia, or other cognitive or medical impairments. States requiring reporting are Delaware, New Jersey, Oregon, Pennsylvania, Nevada, California, and Utah.

Discussion and Recommendations

Resolution 303 addresses a range of complex and important issues, but it primarily calls for TMA to develop policy and/or seek legislative action to ensure certain symptomatic individuals with brain injuries undergo medical clearance for firearm possession if their condition puts them at risk of harm. Firearm safety is a concern for physicians, and TMA has expended much time and study in this area. The resolution calls for reaffirmation of strong national and Texas gun laws, which is already reflected in TMA’s recently updated policy on firearms. TMA Policy 260.015 recognizes gun violence as a public health issue and calls for medical professionals to speak out on the prevention of firearm-related injuries and deaths.

The definition of a “symptomatic TBI” patient is broad and varies greatly, from mild to severe, with symptoms ranging from a short-term headache to long-term cognitive impairment. The variability of what exactly constitutes a symptomatic TBI patient poses potential difficulties in the implementation, regulation, and enforcement of state statute. TMA policy specifically does not support the erosion of physicians’ professional freedoms and seeks to limit the increasing excessive paperwork imposed on doctors; thus, the association would not support any reporting requirements or mandates on physicians. Mandatory reporting may also lead to elevated legal risks for Texas physicians, as well as escalate the shortage of physician appointments to the Medical Advisory Board, which is already insufficiently meeting growing demand. As firearm violence continues to be a concern in the U.S., the advisory board’s medical clearance process is a potential target for those who either support or oppose increased firearm restrictions. For example, if a red flag statute were adopted in Texas, it would possibly involve some form of medical clearance processes at the local or state level.

Resolution 303 calls for the prohibition of symptomatic TBI patients from obtaining or retaining their license to carry (albeit temporarily until medical clearance is received); however, a potential unintended consequence may be the deterrence of individuals reporting their own brain injuries. Caution must also be taken should more physician referrals for prohibitive conditions lead to potential patient distrust and strain on the patient-physician relationship. Another consideration about amendments to state law is potential stigmatization of Texans with TBI-related injuries or disabilities.

Overall, after careful consideration and study, in lieu of adopting Resolution 303, the Council on Science and Public Health makes the following recommendations:

**Recommendation 1:** That the Texas Medical Association support and promote the Texas Medical Advisory Board process by increasing physician awareness and TMA member participation on the Medical Advisory Board to ensure adequate representation, and support potentially needed expansion of this important public service to Texas.

**Recommendation 2:** That TMA promote physicians’ awareness of their ability to report their patients to law enforcement or the Department of Public Safety with concerns regarding their patient’s ability to safely drive or possess firearms.

**Recommendation 3:** That TMA promote a review of the funding of the Medical Advisory Board by the Texas Legislature to assess the potential for expanding the scope of this key public service.
**Related TMA Policy:**

1. 260.015 Firearms
2. 260.079 Mandated Patient Information
3. 260.094 Head Injuries and Sport-Related Concussion
4. 280.021 Stroke Prevention Awareness
5. 115.018 Overwhelming Compliance Mandates and Payment Uncertainty
6. 165.009 Excessive Federal Paperwork Requirements
7. 245.003 Professional Freedom Erosion

**Related AMA Policy:**

10. H-470.963 Boxing Safety
12. H-470.984 Brain Injury in Boxing
13. H-145.974 Increasing Toy Gun Safety
15. H-145.997 Firearms as a Public Health Problem in the United States - Injuries and Death
17. H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care
18. D-145.995 Gun Violence as a Public Health Crisis
19. H-145.996 Firearm Availability
22. H-145.989 Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns
23. H-60.947 Guns in School Settings
24. H-215.977 Guns in Hospitals
25. H-145.999 Gun Regulation
26. H-145.988 AMA Campaign to Reduce Firearm Deaths
27. H-145.972 Firearms and High-Risk Individuals
28. H-145.999 Waiting Period Before Gun Purchase

**Sources:**

9. Texas Health and Safety Code, Sec. 611.004. Authorized Disclosure of Confidential Information Other Than in Judicial or Administrative Proceeding.


14. Texas Brain Injury Alliance. **Texas Brain Injury Statistics**.

15. Texas Department of Public Safety. **Texas Medical Evaluation Process for Driver Licensing**.

16. Texas Health and Human Services. Texas Department of State Health Services. **Resources for Physicians – Medical Advisory Board**.


19. The State of Texas. Legislative Budget Board. **Statewide Services for Traumatic Brain Injuries, Alzheimer’s Disease, and Dementia, 2018**.


Subject: Allow the Possession and Administration of an Epinephrine Auto-Injector in Certain Entities, Resolution 305-A-19 (Tabled C-SPH Report 5 2020)

Presented by: Wendy M. Chung, MD, Chair

Referred to: Reference Committee on Science and Public Health

Resolution 305 by the Harris County Medical Society and the Texas Allergy, Asthma & Immunology Society (TAAIS) was considered at TexMed 2019. The resolution called for TMA to support increasing access to epinephrine auto-injectors (such as EpiPens) in certain public locations. Public locations (certain entities as defined and regulated in state statute) identified in the resolution were amusement parks, child care facilities, camps, restaurants, sports venues, concerts, state government entities, retail facilities, churches, synagogues, youth centers, higher education institutions, and any other entities the executive commissioner of the Texas Health and Human Services Commission determines as appropriate. Other resolves in the resolution called for:

- Annual training of employees or volunteers at these sites;
- State development of policies for these entities; and
- Ensuring immunity for those who, in good faith, initiated treatment using an epinephrine auto-injector as authorized under state rules.

At the TexMed 2019 Reference Committee on Science and Public Health hearing, the author spoke about the effectiveness of increased access to emergency treatment in the school setting and how anaphylaxis occurs among students, teachers, and other school staff. The author also discussed the critical need to have auto-injectors on site in many public locations. Another testifier expressed concern about the high cost of implementing the resolves. The council did not take a position on the resolution at the reference committee hearing. However, the committee noted the complexity of diagnosing anaphylaxis and the potential for inappropriate use of epinephrine. The reference committee recommended the resolution not be adopted. The House of Delegates approved referral of the resolution, and it was referred to TMA’s Council on Science and Public Health and Council on Legislation.

More than a decade ago, Texas passed legislation allowing students (with parent approval and physician instructions) to possess and administer prescribed medicine for asthma or anaphylaxis while at school or at a school-related event. Over recent legislative sessions, TMA has remained engaged with TAAIS and others on policy development related to guidelines for care for those at risk for anaphylaxis, including access to auto-injectors (e.g., Senate Bill 27 [Zaffirini, 2011], House Bill 742 [Hunter, 2011], and Senate Bill 66 [Hinojosa, 2015]).

TMA supported House Bill 4260 by Rep. Philip Cortez in the 2019 Texas legislative session. This bill passed the House early in May 2019 (prior to TexMed). A Senate committee considered the bill in mid-May and finally passed and signed it on the last day of the legislative session. As amended, HB 4260 addresses many of the entities and requirements identified in Resolution 305 – allowing these entities to offer access to epinephrine auto-injectors by employees or volunteers. Governmental entities were excluded. This legislation was signed by the governor in June, effective Sept. 1, 2019. (Refer to Appendix...
A: Recent Texas Legislation on Allergens and Anaphylaxis, which provides a table identifying relevant legislation TMA has monitored and supported).

The Health and Human Services Commission has charged the Texas Department of State Health Services (DSHS) with developing rules to implement House Bill 4260. TMA is in contact with DSHS on its rulemaking for this and related legislation.

Discussion and Recommendations

Food allergies may have a significant negative impact not only on the person with the allergy but also on family and household members. A food allergy can place a person at risk in a restaurant and in almost every setting where food or other contamination can occur, such as a school or even a place of worship. Texas has adopted legislation to support access to emergency treatment for anaphylaxis in a variety of public settings. However, TMA should monitor the implementation of legislation on food allergens.

Current state efforts include the DSHS Food Allergy Ad Hoc Committee, charged with developing guidelines as directed by Senate Bill 869 and other legislation addressing food allergens, and a DSHS standing committee, the Stock Epinephrine Advisory Committee, which has strong allergy and immunology representation from TMA and a key role in how schools – including higher education campuses and now, potentially other settings – should store, maintain, and provide training on the use of auto-injectors.

Entities in individual communities may seek physician support in developing standing orders and providing prescriptions for unassigned auto-injectors in various settings. These are licensed venues, but the definitions, regulations, and the population at these entities seem to vary widely – requiring strong local input to ensure safe access and use. The requirement for training employees in the various venues would likely be tremendously cost-prohibitive, especially in venues where seasonal employees and volunteers change continuously.

Because state legislation has been passed and efforts are already underway, in lieu of adopting Resolution 305, the Council on Science and Public Health makes the following recommendations:

Recommendation 1: That the Texas Medical Association monitor and confer with the Texas Department of State Health Services as it convenes the new Food Allergy Ad Hoc Committee, as well as develop and share information for members on the role of this new ad hoc group.

Recommendation 2: That TMA members be informed of opportunities to be engaged in, monitor, and contribute to the important work of the standing DSHS Stock Epinephrine Advisory Committee.

Recommendation 3: That TMA members be made aware of entities in their communities that may seek physician support in developing standing orders and providing prescriptions for unassigned auto-injectors in various settings.

Recommendation 4: That TMA develop communications for physicians on the expansion of access to unexpired auto-injectors in various public settings.

Related TMA Policy:
55.002 Comprehensive School Health Education in All School Districts
55.019 School Health Education
55.053 Childhood Anaphylactic Reactions
100.029 Requirement for Epinephrine Auto-Injectors in Texas Schools
115.004 Indemnification of Physicians
170.001 Good Samaritan and Charitable Immunity Laws
170.002 Charitable Immunity

Related AMA Policy:
Childhood Anaphylactic Reactions D-60.976
Preventing Allergic Reactions in Food Service Establishments D-440.932
Food Allergic Reactions in Schools and Airplanes H-440.884
Decreasing Epinephrine Auto-Injector Accidents and Misuse H-115.968
## Appendix A: Recent Texas Legislation on Allergens and Anaphylaxis

<table>
<thead>
<tr>
<th>Legislation/Authors/Status</th>
<th>Key points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>86th Legislative Session (2019)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>House Bill 4260</strong> by Representative Cortez and Senator Lucio — passed</td>
<td>In effect Sept. 1, 2019. Directs DSHS to develop rules for the guidelines and for implementation. A physician may prescribe unassigned auto-injectors under a standing order.</td>
</tr>
<tr>
<td><strong>House Bill 1015</strong> by Representative Martinez approved in committee but died on the House calendar</td>
<td>Allows for the placement of warning signs on the use of peanuts in the preparation of foods in certain food service establishments.</td>
</tr>
<tr>
<td><strong>House Bill 1849</strong> by Representative Klick — passed</td>
<td>Effective immediately. Allows for the possession and administration of epinephrine auto-injectors in day care centers. Allows physicians to prescribe epinephrine auto-injectors for a day care center under a standing order for administration. Provides immunity for liability.</td>
</tr>
<tr>
<td><strong>Senate Bill 869</strong> by Senator Zaffirini — passed</td>
<td>Signed by the governor June 14, 2019, and effective immediately. Amends the health and safety requirements in the education code by requiring DSHS to work with an ad hoc committee to develop “Guidelines for the Care of Students With Food Allergies At-Risk for Anaphylaxis.” Applies to school districts and open-enrollment charter schools. The guidelines are to be regularly reviewed and updated.</td>
</tr>
<tr>
<td><strong>Senate Bill 1827</strong> by Senator Menendez — passed</td>
<td>In effect. Amends both the Occupations and the Health and Safety codes to allow for peace officers to possess and use an epinephrine auto-injectors in an emergency. Provides requirements for training in accordance with guidelines developed by DSHS and approved by the Texas Commission on Law Enforcement. Physicians are authorized to prescribe unassigned auto-injectors to law enforcement under a standing order. The physician must periodically review the order and be available for consultation and direction. Allows a pharmacist to dispense the auto-injectors to a law enforcement agency. Requires reporting of the use of an auto-injector and provides immunity from liability for the person who acts in good faith in using the auto-injector.</td>
</tr>
<tr>
<td><strong>House Bill 2243</strong> by Representatives Oliverson and Bowers — passed</td>
<td>Signed by the governor May 24, 2019; effective immediately, amends the state education code by adding access to prescription asthma medicine on public and private school campuses to align with access to epinephrine auto-injectors.</td>
</tr>
<tr>
<td><strong>85th Legislative Session (2017)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Senate Bill 1367</strong> by Senator Menendez — passed</td>
<td>Effective September 2017, directs public health education institutions to develop policies on the administration of epinephrine auto-injectors; provides immunity. Directs DSHS to establish an advisory committee to review the maintenance, training on, and administration of epinephrine auto-injectors to include public higher education institutions and representatives of these institutions on the advisory committee.</td>
</tr>
<tr>
<td><strong>Senate Bill 1683</strong> by Senator Lucio — Senate passed but no House hearing</td>
<td>Required a food service establishment to have a poster on food allergen awareness for food service employees</td>
</tr>
<tr>
<td><strong>Senate Bill 579</strong> by Senator Taylor; comp HB 1583 by Representative Cortez — passed</td>
<td>Allows private schools to adopt policies for access to epinephrine auto-injectors — to be the same as allowed in public and open-enrollment charter schools. Extended to include the transit time to and from school events.</td>
</tr>
</tbody>
</table>
REPORT OF COMMITTEE ON CANCER

CM-C Report 1 2021

Subject: Sunset Policy Review

Presented by: Lynn N. Stewart, MD, Chair

Referred to: Reference Committee on Science and Public Health

TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The Committee on Cancer’s recommendations for retention, amendment, or deletion are as follows:

The committee recommends amending the following policy:

50.006 Colon Cancer Screening: The Texas Medical Association supports state and national legislation in Texas to require insurance for coverage of colorectal cancer screening in which patients and physicians should have the option to utilize a variety of tests, such as fecal occult blood test, fecal immunochemical test, stool DNA test, flexible sigmoidoscopy, colonoscopy, double-contrast barium enema, CT colonography (virtual colonoscopy), or other appropriate techniques, in accordance with the most recently established national guidelines in consultation with interested specialty societies and scientific organizations for the ages, family histories, and frequencies referenced in these guidelines (Amended Res. 303-A-01; amended CM-C Rep. 1-A-11).

Recommendation: Retain as amended.
Subject: Sunset Policy Review

Presented by: Thomas A. Kaspar, MD, Chair

Referred to: Reference Committee on Science and Public Health

House of Delegates policies in the association’s Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the council with recommendations for retention, amendment, and deletion.

The Committee on Infectious Diseases recommends amending these policies as follows:

135.018 Pertussis and Cocooning: The Texas Medical Association (1) actively promotes the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices recommendations on the use of the tetanus-diphtheria-acelluar pertussis (Tdap) vaccine, and provide education and assistance to physicians with strategies for implementing pertussis vaccination in various settings, which includes providing tools to promote Tdap for postpartum pregnant women and their families, as well as the use of Tdap in emergency departments; (2) supports increased physician awareness regarding payment for diphtheria-tetanus-pertussis (DTaP) and Tdap vaccine under health insurance plans; (3) works with the Texas Department of State Health Services (DSHS) and local public health agencies to ensure current infectious disease data, guidance on responding to disease outbreaks, and physician-focused materials are disseminated to physicians (TMA can work with stakeholders to encourage information-sharing among public health agencies, hospitals, and health care professionals); (4) works with DSHS on reviewing Texas notifiable condition requirements and recommending enhancements to support improved surveillance of pertussis deaths among infants; and (5) advocates for the allocation of additional DSHS resources for Tdap vaccine that will assist local health departments during outbreaks (CM-CID Rep. 1-A-11).

95.033 Drug Shortages and Physician Communications: The Texas Medical Association will work with the AMA and other appropriate federal agencies to increase federal monitoring of potential drug and medical equipment shortages, and enhance communications with physicians regarding drug shortages and alternative treatments (CM-ID Rep. 2-A-11).

135.02 Fairness in Timely Delivery of Vaccines: The Texas Medical Association advocates for the importance of ensuring vaccine supply to physicians, and supports strengthening the supply chain network and electronic allocation and reporting systems to ensure fair and timely delivery of vaccines to all available sources that participate in the vaccination of patients (Res. 209-A-11).

135.019 Promotion of Antimicrobial Stewardship: The Texas Medical Association (1) supports physician efforts to develop and promote comprehensive antibiotic stewardship and infection prevention programs in inpatient and outpatient health care facilities, and (2) encourages physicians to participate in education programs and to use current evidence-based resources such as those provided by professional societies and the Centers for Disease Control and Prevention (CDC). Physicians are encouraged to use the available patient education tools to
inform their patients about antimicrobial therapy, prescribing guidelines, and appropriate use of antibiotic therapies. This includes, but is not limited to, the proper use and handling of antibiotics as prescribed by their physician, and the information that antibiotics should not be shared, are not needed and are inappropriate for viral infections; and (2) (3) recommends that the Texas Department of State Health Services (DSHS) and medical schools inform medical students and residents about antimicrobials and the impact of antimicrobial resistance on public health, patient outcomes, and health care costs, and that TMA collaborate with DSHS to promote the use of evidence-based programs for the continuing education of physicians on the problem of antimicrobial resistance; and (4) encourages continued scientific research into the impact of antimicrobial stewardship programs to reduce antibiotic resistance, such as CDC’s Get Smart program. (CM-CID Rep. 3-A-11).

**Recommendation:** Retain as amended.
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The committee reviewed the policies and offers recommendations for the following policies as summarized in this report.

The committee recommends amending these policies as follows:

**140.010 Newborn Genetic Screening:** The Texas Medical Association supports universal screening in Texas of all core and secondary conditions identified by the U.S. Department of Health and Human Services’ Advisory Committee on Heritable Disorders in Newborns and Children in its Recommended Uniform Screening Panel for newborns. TMA recognizes that a comprehensive newborn screening program should consist of a statewide continuum of services coordinated by the Texas Department of State Health Services, including education, screening, tracking, follow-up, diagnosis, treatment, and management of those conditions identified in the program. To ensure early detection and appropriate follow-up care for all babies born in Texas with genetic diseases or congenital conditions, including critical congenital heart defects or and hearing loss, all delivery care attendants are urged to participate in the state’s newborn screening program and to use the state’s available tracking and reporting systems. (CSA Rep. 3-A-07; amended CM-MPH Rep. 2-A-11).

Other components of the state’s newborn screening program should include an accountable stakeholder group, an independent clinical advisory group, use of a regional specialty services process, and use of evidence-based measures defined as science published in peer-reviewed journals and supported by a consensus of experts. Ongoing and continuous quality evaluation and improvement is critical and must protect patient confidentiality and ethical handling/storage of dried blood spots. Education efforts should include parents/families, state policy makers, clinicians, and hospitals, and medical schools and institutions. (CSA Rep. 3-A-07; amended CM-MPH Rep. 2-A-11).

**140.002 Prenatal and, Perinatal, and Postpartum Care:** The Texas Medical Association supports a system to meet the needs of low- and high-risk perinatal and, prenatal, perinatal, and postpartum care in both the private and public sectors based on the coordinated efforts of private physicians; medical schools; federal, state, and local health agencies; the state perinatal quality collaborative; and other available resources. (Committee on Maternal and Child Health, p 114, A-91; reaffirmed CM-MPH Rep. 3-A-01; reaffirmed CM-MPH Rep. 1-A-11).

**Recommendation 1:** Retain as amended
REPORT OF COMMITTEE ON CHILD AND ADOLESCENT HEALTH

CM-CAH Report 1
2021

Subject: Sunset Policy Review

Presented by: Kimberly C. Avila Edwards, MD

Referred to: Reference Committee on Science and Public Health

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The committee reviewed the policies and offers recommendations as summarized in this report.

The committee recommends retention of the following policies:


Recommendation 1: Retain.

The committee recommends amending these policies as follows:

55.033 Children’s Mental and Behavioral Health: Texas has a relatively young population, with about 28% of Texans under the age of 18. Significant brain development occurs in childhood and adolescence, making it a critical point in an individual’s lifespan during which mental and behavioral health disorders may emerge. TMA recognizes that many mental and behavioral health disorders of childhood and adolescence are the basis of both physical and mental disease throughout an entire lifespan, affect individuals’ physical, mental, and social health in adulthood. Childhood and adolescence are critical times for brain development; consequently, many mental disorders develop during these periods. As such, the evaluation and treatment of these disorders in childhood and adolescence are critical to the health of Texans at all ages.

Managing mental and behavioral health disorders among children requires multiple strategies.

1) Physician Education. All physicians should have adequate information that enables them to recognize common mental disorders. Primary care physicians should receive the necessary training, support, and educational resources to prevent, properly screen for, diagnose, and treat mental and behavioral health disorders. They should be provided educational tools regarding the screening, diagnosis, and current available treatment modalities for mental health disorders including but not limited to such as attention deficit disorder, autism, substance use disorder,
mild depression, and mild anxiety. TMA can provide resources for physicians on national screening and treatment guidelines, and billing and coding information.

2) Practice. Access to care remains a critical issue for children and adolescents with mental health disorders, especially underserved children. A physician-led medical home, therefore, can play an important role in recognizing, consulting, and treating children with mental health disorders by following the American Academy of Pediatrics and United States Preventive Services Task Force (USPSTF) recommendations for screening children and adolescents for mental health and substance use disorders.

All physicians who see and treat children should be able to recognize and either treat or refer children with obvious mental illness health disorders including and substance abuse disorder use disorders. Because school is the "workplace of the child," primary care physicians should have knowledge of the demands and resources of their local school districts.

3) Advocacy. TMA should facilitate and advocate for:
   a. Continuing mental health education programs for physicians and mental health care providers regarding child and adolescent mental health and substance abuse issues;
   b. Medical schools and graduate medical education programs that to recognize the role of primary care physicians in the diagnosis and treatment of mental and behavioral health conditions and provide effective training, support, and research in all aspects of these areas child and adolescent mental health and substance abuse;  
   c. Continuing dialogue and networking with the public mental health community on these issues; 
   d. Minimizing youth exposure to advertisements for legal addicting substances; 
   e. Positive mental health messages that counteract tobacco and alcohol advertisements; 
   f. Strong children’s mental health networks throughout the state; 
   g. Emphasizing pediatric mental health education for all physicians who see children, 
   h. Additional support for the expanded training of mental health professionals and increased support for improved access to mental health services, that will establish increased adequate numbers and quality of mental health professionals throughout the state; 
   i. Coordinating with the educational system to ensure a school environment that supports mental health for mentally healthy schools, free of stigma related to mental or behavioral health issues; and 


Recommendation 2: Retain as amended
The committee recommends deletion of the following policy:

\textbf{285.002 Weight Requirements:} The Texas Medical Association believes that while a healthy weight should be encouraged for all sports participants, schools are urged not to make weight requirements a prerequisite for any sports activity and that all students, regardless of weight, should be allowed to participate on sports teams (Committee on School Health, p 114, I-90; amended CM-CAH Rep. 2-A-01; amended CSPH Rep. 3-A-11).

\textbf{Recommendation 3:} Delete.
Subject: Cardiac Arrest as a Reportable Condition

Presented by: Richard Bradley, MD, Chair

Referred to: Reference Committee on Science and Public Health

Out-of-hospital cardiac arrest is a potentially preventable and treatable condition that could see improved survival outcomes with enhanced data collection and sharing. Data reporting and response initiatives are developing at the state and national levels, including the Texas Cardiac Arrest Registry to Enhance Survival (CARES) and the American Heart Association’s (AHA’s) Telecommunicator CPR Taskforce. Texas CARES is a partnership of emergency medical services (EMS) agencies, health care providers, and university researchers committed to improving out-of-hospital cardiac arrest reporting and response. The AHA taskforce engages in research and recommends policy to improve 9-1-1 operator and bystander CPR response to sudden cardiac arrest. Several Texas Medical Association members are involved in these programs. The committee believes the state should collect data on out-of-hospital cardiac arrest events and report the data to an out-of-hospital cardiac arrest registry. The Committee on EMS and Trauma asks that TMA support recognizing sudden cardiac arrest as a reportable condition in Texas.

As of 2020, 28 states and the District of Columbia participate in the national CARES, managed by Emory University. In addition, 45 community sites in 14 additional states collect and submit data voluntarily. CARES captures data for 45% of the U.S. population. Texas participates in CARES through McGovern Medical School at UTHealth; however, the school has no mandate to, and may not financially be able to, continue to support this program. Only a portion of cardiac arrests in Texas are reported, because reporting data to Texas CARES is voluntary. State recognition of out-of-hospital cardiac arrest as a reportable condition would streamline and bolster data collection and reporting and guarantee continuity.

The committee believes that strong data reporting will help identify and implement the proper response to these time-sensitive, sudden, and deadly medical events. Cardiac arrest is a potentially preventable and treatable condition that results in the death of more than 475,000 Americans per year, and more than 350,000 of those cardiac arrests occur outside of the hospital. Cardiac arrest survival is worse in communities of color and among those with lower socioeconomic status, making out-of-hospital cardiac arrest an issue of health equity. Texas already mandates reporting on many other conditions, such as cancer, drowning, controlled substance overdoses, lead poisoning, spinal cord injury, and traumatic brain injury.

A high-quality chain of survival – a timely response plan – has the potential to improve the survival rate of sudden cardiac arrest. Such plans consist of rapid activation of the emergency response system, immediate high-quality CPR, rapid defibrillation, basic and advanced emergency medical services, and advanced life support and post-arrest care. The survival outcomes from out-of-hospital cardiac arrest vary widely across the country, from 3% to 35%. A robust cardiac arrest registry would bolster an evidence-based chain of survival by providing the data necessary to adjust and improve response plans as new interventions are tried and evaluated. Mandatory reporting of cardiac arrests to a state registry also would give physicians and policymakers much richer data on the extent of socioeconomic and racial disparities, and enable the design and evaluation of interventions to reduce them.
A statewide out-of-hospital cardiac arrest registry will allow researchers, public health experts, policymakers, and the public to view the state of out-of-hospital cardiac arrest outcomes and the direct, effective, evidence-based interventions that improve these outcomes. Data from CARES are released in two ways: (1) agencies that contribute can see their own data, and (2) researchers can submit a research request to the CARES board. Scientifically valid requests can access deidentified data.

The Committee on EMS and Trauma proposes the following:

**Recommendation 1:** That the Texas Medical Association support amending the Texas Health and Safety Code to mandate data collection on all out-of-hospital cardiac arrests in Texas in which emergency medical services personnel (EMS) attempt resuscitation, including management and evaluation by EMS personnel and outcome data from hospitals.

**Recommendation 2:** That TMA support management of Texas out-of-hospital cardiac arrest data by the Texas Cardiac Arrest Registry to Enhance Survival with funding from the state for the organization’s management services, data collection, and sharing.

**Recommendation 3:** That TMA supports the appropriate application of data protection and security laws regarding out-of-hospital cardiac arrest patient data collected by the state or a contracted entity.

**References**

1. TX-CARES.
2. Healthy People 2030. Cardiac Arrest Registry to Enhance Survival (CARES).
At its 2021 Winter Conference meeting, the committee met with SouthEast Texas Regional Advisory Council (SETRAC) Chief Executive Officer Darrell Pile to discuss SETRAC’s adoption of a new emergency department (ED) “saturation” policy in place of traditional ED diversion policy. All hospitals in SETRAC’s designated region follow saturation policy. It has been in effect regionally since 2013.

SETRAC is one of 22 Regional Advisory Councils (RACs) in the state contracted by the Texas Department of State Health Services (DSHS). RACs are administrative bodies responsible for developing, implementing, and overseeing emergency medical services (EMS) trauma system plans in a designated region. SETRAC covers nine counties, including Harris and Fort Bend. DSHS asks each RAC to develop its own ED diversion policy. SETRAC’s policy was brought to the committee’s attention by Kenneth Mattox, MD, a committee consultant and TMA member involved in SETRAC. The saturation policy was developed by a diverse group of end users, including hospital and EMS leaders.

Traditional emergency department diversion policy allows hospitals to communicate to EMS agencies that they are on “diversion status” when the emergency department is full or the ED staff find the situation to be unusually taxing. Hospitals use this status to avoid emergency patients arriving at an overcrowded ED and experiencing delayed care due to lack of capacity. When activated, diversion status directs EMS to transport patients to another hospital. If all hospitals in a region are on diversion status, or if there is only one hospital for a wide area, which is not uncommon in rural Texas, the ambulance could be directed to drive extraordinary distances that leave the patient without hospital care in time-sensitive emergency medical situations. In Texas, given the large number of rural hospital closures over the past several years, this scenario is not unimaginable.

Ambulance diversion was developed to be a short-term and rare option for hospitals to cope with extraordinary circumstances. However, use of the status has become common in the U.S., with an average of about one incidence of ambulance diversion per minute. A study conducted in Houston found that hospitals were on diversion more than 27% of the time for 23 of 30 months. High-frequency diversion use is a result of consistently high emergency department traffic. Another Houston study found a possible effect of EMS diversion on mortality rates in Texas. Death rates of patients hospitalized on significant diversion days, defined as days when both Level I hospitals were on diversion for more than eight hours, were higher than nonsignificant diversion days (no statistical significance). Percentage of deaths is calculated among all trauma patients, including those transferred. Authors of the study concluded: “1) delays in treatment of trauma patients caused by hospital diversion may increase mortality; 2) diversion is frequently caused by saturation of the ER [emergency room]; and 3) primary care-related ER use of trauma centers contributes to ER saturation.”

Saturation is a description of status rather than an EMS directive. By directing health care professionals to drive to another facility, diversion status could delay care further than if the patient were admitted to an overwhelmed emergency department. SETRAC’s system asks hospitals to use saturation status in place of diversion, communicating the emergency department’s condition and enabling EMS agencies to make
informed decisions. Medical directors participating in SETRAC’s workgroup designing saturation policy provided insight on the information EMS agencies need to determine where to transport a patient, rather than having a licensed hospital issue a proclamation to divert. If EMS believes taking a patient to a nearby saturated facility increases the chance of a positive health outcome or survival compared with driving lengthy distances to seek care, it can choose the closer facility. Saturation status lasts four hours; then the hospital must redefine its status. SETRAC’s system is a mechanism for increased EMS-hospital communication, rather than hospitals telling EMS their current capabilities. In addition to SETRAC, trauma service areas G, H, Q, R, U, and V also use a saturation system.

SETRAC developed the saturation system because stakeholders felt diversion was not working. Direction to divert was not well defined and could be used liberally to slow down the pace of activity. For example, some facilities would place themselves on diversion but still accept transfer patients. Some EMS agencies would bypass the hospital on diversion, and others would not, until they became one of many ambulances waiting to offload patients. SETRAC felt EMS agencies needed better descriptors of hospital capabilities and statuses to make better decisions on which hospital could best serve the patient. For example, if the patient is suspected of having a long-bone fracture, EMS can easily see if orthopedic service is available that day. Hospitals on saturation can describe their circumstances with phrases such as “eight ambulances waiting,” “no ICU beds available,” or “(number) patients holding in ER for a bed.”

Since addressing the overarching issue of emergency department capacity will take longer for physicians, EMS agencies, and hospital stakeholders to address systematically, the committee supports SETRAC’s policy change as a means to test whether this approach improves timeliness of care and patient outcomes in addition to improving communications between ED and EMS systems. After discussing SETRAC’s proposal, the committee recommends that TMA support adoption of SETRAC’s saturation language in lieu of conventional ED diversion policy.

The committee does recommend that further data be collected and efficacy of the policy be shown before supporting policy adoption statewide. SETRAC expects to release a report to hospital system presidents in the near future that evaluates the saturation policy during the COVID-19 crisis and Texas’ recent winter storm emergency, when ED utilization and accessibility challenges were exacerbated. The region currently can report individual facility status changes by day over time or hourly to determine trends in peak times for both hospitals and EDs. SETRAC also collects data to assess the frequency with which individual hospitals reported saturation over a single month. Some were saturated for more than 70% of the month. Hospital system presidents have examined the data to determine if their system could help individual hospitals that are frequently saturated.

Because the Department of State Health Services currently tasks each Regional Advisory Council in Texas with developing its own diversion policy, its rules would need to be amended to coordinate statewide ED diversion policy reform. The committee believes that expressing support for the SETRAC policy will help facilitate DSHS and other RACs in revisiting existing diversion policies.

The Committee on EMS and Trauma proposes the following:

Recommendation 1: That the Texas Medical Association support exploring the Southeast Texas Regional Advisory Council’s (RAC’s) use of emergency department saturation status in place of an emergency department diversion policy to describe when hospitals within the region are experiencing high patient volume. Each RAC should test saturation policy and gather data and feedback before TMA recommends statewide adoption. The policy should be adjusted or expanded by each RAC pending periodic reviews of data regarding policy efficacy and patient outcomes within its unique region.
**Recommendation 2:** Any hospital that adopts a saturation policy in lieu of diversion must consult emergency physicians and other emergency department personnel to ensure the policy is descriptive rather than directive, and that it enables emergency medical services (EMS) medical directors and their staff to make informed decisions for the benefit of patient health and survival outcomes.

**Recommendation 3:** That TMA request that the Texas Department of State Health Services and the Governor’s EMS and Trauma Advisory Council evaluate data collected by RACs over the course of this policy change and make recommendations accordingly.

**References:**

1. DSHS. [Regional Advisory Councils](#).
2. DSHS. [Metropolitan, nonmetropolitan, frontier county map of Texas](#).
Joint Report 1 2021

Subject: Regulatory Recommendations for Bed Bugs, Resolution 307-A-19
(Tabled Joint Report 3 2020)

Presented by: Thomas A. Kaspar, MD, Chair, Committee on Infectious Diseases, and
Wendy M. Chung, MD, Chair, Council on Science and Public Health

Referred to: Reference Committee on Science and Public Health

Resolution 307-A-19 was considered at TexMed 2019, calling for the Texas Medical Association to
support increased regulation to manage the health effects associated with bed bugs (Cimex lectularius).
Identifying an increase in bed bug infestations, the resolution noted that certain individuals such as
children, the elderly, and those who are disabled were facing physical, mental, and financial harm.
The resolution recommended that TMA consider bed bugs a public health issue and called on TMA to
appoint a TMA body to seek a mechanism for the collection, study, and public reporting of data on the
impact of bed bugs on the public health of Texans, and to:

• Collaborate with the Texas Association of City and County Health Officials (TACCHO) to develop
guidelines for local health authorities using an integrated pest management approach to bed bugs;
• Collaborate with the Texas Department of State Health Services (DSHS) to support regulatory
changes that encourage the reporting, treatment, and study of bed bugs in state-supported living;
• Seek legislation to address the public health issue of bed bugs in Texas, especially when affecting
vulnerable populations or inhabitants of multifamily dwelling units (MDUs); and
• Carry this resolution, or a similar one, to the American Medical Association to develop public health
recommendations and seek regulatory or legislative action for the management of health effects
associated with bed bugs as a national public health issue, especially in regard to the collection, study,
and public reporting of data on the impact of bed bugs; the effect of bed bug infestations on MDUs;
and the role of the U.S. Department of Housing and Urban Development in bed bug management.

Prior to this resolution submission, Alice Gong, MD, 2018-19 chair of the council, sent a letter in
response to a related inquiry describing TMA’s review of the issue and the authority local public health
has in bed bug management. This letter is provided for reference at the end of this report as Appendix A.
Revisiting the issue at TexMed 2019, the council reviewed the resolution and took no formal position on
the resolves but noted that some of the information in the resolution lacked scientific evidence and that
there was a high administrative burden for local public health to implement the proposed activities.
Resolution 307-A-19 was referred to the council for study, and the council referred Resolution 307-A-19
to the Committee on Infectious Diseases to study and compile a joint report to address the resolution.

Bed Bugs and Bed Bug Management
Bed bugs are ectoparasites that thrive throughout the United States and the world. These parasites have
been common in American households for decades, but their presence began to decline in the 1940s when
dichlorodiphenyltrichloroethane – known as DDT – and other insecticides became available. However,
due to increased resistance to insecticides, in combination with increased air travel and waning societal awareness of bed bug prevention methods, bed bugs reemerged as a significant problem in the U.S. beginning in the 1990s, and reports of infestations have only continued to increase since that time.

No federal agency or other national entity monitors bed bugs in the U.S., but the Centers for Disease Control and Prevention (CDC) affirms that bed bugs have been reported in all 50 states. Only one state, Kansas, requires mandatory reporting of bed bugs found in lodging establishments to a state-level agency, the Office of Agriculture. Several states have laws dictating the necessity of maintaining bed bug-free environments but do not assign responsibility to a specific party. Some cities around the country have issued ordinances for the reporting or disclosure of bed bugs; these are overwhelmingly focused on landlord/tenant relations and hotel management.

Following a 2010 joint statement on bed bugs by CDC and the Environmental Protection Agency (EPA), the Federal Bed Bug Workgroup was convened to develop a strategy on bed bugs. Made up of representatives from several federal agencies that are involved in different critical components of bed bug management (EPA, Department of Housing and Urban Development, CDC, National Institutes of Health, Department of Defense, and Department of Agriculture), the workgroup released its Collaborative Strategy on Bed Bugs in 2015. This strategy identifies key stakeholders as state and local governments and community entities, specifically listing housing providers, pest management firms, and local health departments as essential to lowering the cost of prevention and treatment and to understanding the needs of a specific area. The integrated pest management approach, which focuses on comprehensive and responsible bed bug prevention and treatment through education, engagement, and multi-organizational cooperation, is deemed the best practice for bed bug management.

Bed bugs survive by feeding on the blood of sleeping humans and certain animals. At present, there is no recorded case of bed bugs transmitting disease to humans.¹ Potential health effects identified by CDC include itching and skin irritations from bed bug bites, insomnia, stress, and anemia. CDC states these are usually rare, and in the case of anemia, are concurrent with other risk factors for anemia and present in cases of enormous and extreme infestations.

EPA has approved 300-plus pesticide products of different categories for use in bed bug management, most of which are available over the counter to the public.² EPA notes the difficulty in eliminating bed bugs if pesticides are not used according to the labeling of the products. This could be a factor in the increasing resistance of some bed bugs to certain types of pesticides and the increasing presence of bed bugs. Due to the potential of misuse and resistance, many bed bug experts recommend using professional services, although there is a recognized financial barrier to this option.

Texas Bed Bug Statutes

Texas Health and Safety Code Chapter 341, Minimum Standards of Sanitation and Health Protection Measures, defines bedbugs as a public health nuisance and requires a person to abate the nuisance in the place the person possesses. It also directs the local health authority to order the person responsible to abate the nuisance, once the authority is aware of the problem.

The term “nuisance” is based on common law. CDC has referred to a nuisance as an “unreasonable interference with a right common to the general public, such as a condition dangerous to health.”³ This is consistent with Texas Health and Safety Code Chapter 343, Abatement of Public Nuisances, which concerns sanitation and environmental quality matters and identifies several issues that can be considered
a public nuisance. Texas also has nuisance abatement statutes for other common nuisances (see Chapter 125 of the Civil Practice and Remedies Code) involving certain unlawful activities on private property.

At the state level, DSHS can receive public nuisance complaints, which it will refer to the appropriate municipality or county. In counties that do not have a local health department or public officials to enforce local health codes, DSHS’ regional staff respond to public nuisance complaints.4

Local jurisdictions commonly receive and have authority to abate a nuisance in a wide manner based on the type of nuisance. A public official can identify a nuisance on private property as a public nuisance when the matter has an impact on the public. The response from public officials includes confirming the nuisance and providing information on how to address the nuisance. For example, a recommendation could involve the removal of rubbish causing foul odors, used tires, abandoned automobiles, or a dilapidated/unsafe building, or spraying mosquito pools. A property owner who does not comply with addressing the nuisance could be found in violation and be penalized.

Expert Commentary
Both the council and the committee have thoroughly studied and sought the expertise from various local, regional, and state-level public health experts, researchers, associations, and other organizations regarding bed bugs, data, management, and statutes. A general overview of the findings are as follows.

• The Texas Association of City and County Health Officials confirmed that local health departments have full authority to respond to bed bug infestations, but enforcement is difficult in many settings and “becomes a revolving door of complaint, investigation, remediation and compliance.” Bed bugs can become a significant problem for many; however, they do not transmit disease and are not identified as a public health threat. TAACHO also recognized that although laws could be strengthened to require certain entities to use pest control services, this will not completely address the common issues of ongoing noncompliance.

• Texas Department of State Health Services:
  • The Division of Laboratory and Infectious Disease Services reported that because no evidence supports bed bugs as disease vectors, it was not active in addressing bed bug infestations.
  • The Zoonosis Control Branch reported that the lack of a connection between disease transmission and bed bugs meant the branch did not address them as a public health threat.
  • The Consumer Protection Division does address bed bugs and has plans to work with the Regional and Local Health Operatives Division at DSHS to establish a stronger process in the regulation of public health nuisances, including bed bugs, in areas where there is no local health authority. In instances where bed bugs affect private citizens in their private homes, DSHS has no regulatory authority.

• Texas A&M AgriLife Extension Service, which specializes in developing educational and training materials and programs on integrated pest management for the public, has data showing bed bugs are an increasing problem with their resurgence, partially due to pesticide resistance and to endemic populations left in multifamily housing units after insufficient treatments.5 Although more research on the subject would be beneficial, data are not needed to sufficiently address bed bug infestations, and any mandate or legislation would also have to address the financial burden of treatment, especially in affordable housing complexes.

• Texas Tenant’s Union stated that bed bug infestations seemed to be increasing and are a significant concern for tenants across the state. A major barrier to reducing the occurrence of bed bug
infestations is the Bed Bug Addendum, used almost universally in the state by those leasing
apartments and rental properties. The limited time a tenant has to declare the leased space bed bug-
free per the addendum is unrealistic, and the subsequent financial burden on tenants when they do
find bed bugs disproportionately affects lower-income individuals.

- Cities of Dallas and Garland public health officials: Although the two cities had variances in their
approaches, they both expressed no need for more data to define bed bugs infestations as a growing
problem or to appropriately address the issue. Both cities did mention their ordinances could be
strengthened to encourage enforcement and that on a state level there could be better-defined
responsibility for bed bug management in landlord/tenant agreements.

Although research on bed bugs is limited, studies have looked at the emotional and mental health
consequences of bed bugs, the possibility of disease transmission, and cases of severe health outcomes
such as iron-deficient anemia. No study conclusively established bed bugs as disease vectors.6 In the rare
cases of severe anemia with bed bugs present, studies showed that bed bug infestations were extreme and
that other risk factors such as poor diet, cognitive impairment, and financial barriers to pest treatment
were present.7 Cross-sectional studies have shown that those exposed to bed bug infestations are at risk
for sleep disruption, anxiety, and depression.8,9

An analysis (summary table in Appendix B) of current practices in other states and cities found that
although some states do have specific statutes addressing bed bugs, they are almost always designed to
define responsibility in landlord/tenant relationships. Very few issue detailed mandates. This is likely due
to the variability in resources and needs of cities throughout a state. Since integrated pest management
requires the collaboration of various stakeholders using their expertise to address the unique challenges of
pest management in a community, the best examples of successful bed bug infestation reduction are
municipally led.10 Links to examples of some cities’ approaches are provided at the end of this document.

Discussion and Recommendations

The resolution called for TMA to recognize bed bug infestations as a public health issue. While there is
not a definition of “public health issue,” in its process of setting priorities, the council has always assessed
the prevalence of an issue; the population harmed; the cost/burden of disease; the available options and
measures for prevention; the potential for increasing risk and burden with the disease/harm; and finally,
an awareness of the physician role in addressing the issue. Other factors to consider are these:

- The cost of bed bug management can indeed be high for a family and certainly for residential
facilities such as long-term care facilities.
- In a multifamily residential facility such as an apartment complex, identifying who is to be
responsible for bed bug management can vary; a local ordinance may require the apartment owner or
landlord to manage the infestation, not the resident.
- There are many different types of products for bed bug management, and not all are effective/tested;
in most cases, multiple applications are needed. Nationally, concerns are growing about pesticide
misuse/overuse, which could be associated with increasing resistance to these products.
- Many local jurisdictions have developed public information campaigns on bed bugs. Considerations
may be given to the effectiveness of campaigns on informing the public how to identify infestations
early (when they are most manageable).
- Regulatory measures may be considered to manage bed bug infestations in facilities where vulnerable
residents live and are cared for, such as long-term care facilities or assisted living centers.
It is important to note that these concerns are not medical in nature; although there are established negative consequences from a bed bug infestation, it remains unclear what role a physician could play in resolving them, considering the lack of a connection between bed bug infestation and disease transmission.

Based on this point and the research detailed in this report, both the Committee on Infectious Diseases and the Council on Science and Public Health recommend the following, in lieu of passing Resolution 307-A-19:

**Recommendation 1:** That Texas Medical Association support the joint statement by the Centers for Disease Control and Prevention and the Environmental Protection Agency (EPA), which defines bed bugs as a pest of significant public health importance and recognizes that bed bugs are a continuing problem for residents in the state of Texas.

**Recommendation 2:** That TMA encourage the further development of effective and affordable pest treatment options and expanded access to current evidence-based options approved by EPA or other reputable entities.

**Recommendation 3:** That TMA supports better public and physician education on bed bug identification, treatment, and threats to public health.

**Recommendation 4:** That TMA supports additional research on bed bug incidence to the extent that is practical and feasible and in line with methods used for similar public health pests.

**Recommendation 5:** That TMA encourages municipal efforts to implement measures based on the published integrated pest management approaches and on other evidence-based examples for bed bug treatment practices.

**Resources on Bed Bugs**

- Integrated pest management: [Collaborative Strategy on Bed Bugs](http://www.cdc.gov/parasites/bedbugs/health_professionals/index.html)
- Environmental Protection Agency: [Bed Bug Clearinghouse by Audience](http://www.cdc.gov/parasites/bedbugs/health_professionals/index.html)
- Texas A&M AgriLife Extension: [Insects in the City](http://www.cdc.gov/parasites/bedbugs/health_professionals/index.html)
- City and state examples of bed bug management:
  - Chicago
  - Michigan
  - New York City
  - Ohio
  - Seattle
  - Toronto

**References:**


Appendix A.

March 5, 2019

Wendell H. Williams, MD
Sent via email at: WHWilliams@mdanderson.org

Dear Dr. Williams,

Thank you for reaching out to the Texas Medical Association on potential action for the prevention of bed bug infestations. I serve as the chair of TMA’s Council on Science and Public Health, which considers physician requests on science and public health matters.

The council’s review of each issue includes getting input from members and consultants to the council and from those with experience and expertise on the topic. State statute directs that the management of bed bug infestations is the responsibility of local public health entities, in their role of “nuisance management.” As such, we conferred with physicians who serve in public health positions as well as the Texas Association of City and County Health Officials and the medical officer on infectious diseases at the Texas Department of Health Services.

Based on the information we have received, the council is not recommending that TMA develop policy or encourage legislation on this topic. We recognize this is a significant concern for many families and especially households with members with a chronic health condition, but we have not identified data indicating this warrants legislative action. We do understand that physicians can be better informed on the prevalence of such infestations and the potential for harm to some individuals and will propose developing an information sheet for physicians on this topic.

As a neonatal-perinatal physician who cares for fragile newborns, I understand the discomfort and financial and social stress a family faces when its home is infested with bed bugs. However, state law already has designated how this is to be addressed. You have increased our awareness of this issue, and we encourage you to consider developing a blog post for TMA so it can be more widely understood, especially as there is some indication that infestations increase as the season gets warmer.

The council greatly appreciates your interest and your efforts to engage others in the prevention and management of infestations; we hope you help us promote awareness of this topic in the future.

Sincerely,

Alice Gong, MD Chair
TMA Council on Science and Public Health
# Appendix B.

## State Bed Bug Laws, November 2016 – (pulled from National Pest Management Association with added TMA comment)

<table>
<thead>
<tr>
<th>State</th>
<th>Citation &amp; Title</th>
<th>Summary</th>
<th>TMA Comments</th>
</tr>
</thead>
</table>
| Alabama   | ALA. ADMIN. CODE § 420-3-11-.12, Construction, Maintenance, and Operation of Hotels - Insect and Rodent Control | Hotels shall be kept in such condition as to prevent the harborage or feeding of insects or rodents. Insects include “bed bugs.” Guest rooms shall be immediately closed if an infestation is discovered, until it is determined the problem is abated. | - Not unique to bedbugs (included as “insects”);  
- Relates specifically to hotels;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement |
| Arizona   | ARIZ. REV. STAT. § 9-500.31, Prohibition on adopting landlord tenant bedbug control requirements, city or town | A city or town shall not adopt requirements by ordinance or otherwise for landlords or tenants that relate to the control of bedbugs as defined in section 33-1319, other than the requirements prescribed by section 33-1319. A city or town may adopt requirements relating to the proper disposal of items that are infested with bedbugs. | - Relates to defining landlord/tenant responsibilities;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement |
| Arizona   | ARIZ. REV. STAT. § 11-269.11, Prohibition on adopting landlord tenant bedbug control requirements, Board of Supervisors | The Board of Supervisors shall not adopt requirements by ordinance or otherwise for landlords or tenants that relate to the control of bedbugs as defined in section 33-1319. The Board of Supervisors may adopt requirements relating to the proper disposal of items that are infested with bedbugs. | - Relates to defining landlord/tenant responsibilities;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement |
| Arizona   | ARIZ. REV. STAT. § 33-1319, Bedbug control; landlord and tenant obligations; definitions | The landlord shall provide bedbug educational materials to existing and new tenants. Landlord shall not knowingly rent a unit that has a bed bug infestation. Tenant shall not knowingly bring materials into the rental unit have been infested by bed bugs. | - Relates to defining landlord/tenant responsibilities;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement |
| Arizona   | ARIZ. REV. STAT. § 36-601, Public nuisances dangerous to public health | The presence of ectoparasites, such as bedbugs, in any place where sleeping accommodations are offered to the public is declared a public nuisance dangerous to the public health. | - No reporting requirement;  
- Relates only to public spaces |
<table>
<thead>
<tr>
<th>State</th>
<th>Citation &amp; Title</th>
<th>Summary</th>
<th>TMA Comments</th>
</tr>
</thead>
</table>
| California | **CAL. CODE REGS. Section 1942.5, 1954.05, 3, Pt. 4, Title 5, Ch. 2.8, 1954.600, 1954.601, 1954.602, 1954.603, 1954.604, 1954.605** | Lists the duties of landlords and tenants with regard to the treatment and control of bed bugs. The law requires a landlord to provide a prospective tenant information about bed bugs, as specified. The law requires that the landlord provide notice to the tenants of those units inspected by the pest control operator of the pest control operator’s findings within 2 business days, as specified. The law prohibits a landlord from showing, renting, or leasing a vacant dwelling unit that the landlord knows has a bed bug infestation, as specified. | - Relates to defining landlord/tenant responsibilities;  
- No mention of medical/health concern or physician involvement |
| Colorado   | **Colo. Rev. Stat. § 38-12-10**                                                   | Concerns bed bugs in residential premises, and, in connection therewith, establishes duties for landlords and tenants in addressing the presence of bed bugs.                                                                 | - Relates to defining landlord/tenant responsibilities;  
- No mention of medical/health concern or physician involvement |
| Connecticut| **CONN. GEN. STAT. § 47a-7a**                                                     | Establishes a framework to identify and treat bed bug infestations in residential rental properties, including public housing but excluding detached, single-family homes. It sets separate duties and responsibilities for landlords and tenants, including notice, inspection, and treatment requirements. It also gives landlords and tenants remedies when either party fails to comply with these duties and responsibilities. | - Relates to defining landlord/tenant responsibilities;  
- No mention of medical/health concern or physician involvement |
| Florida    | **FLA. STAT. § 83.51, Landlord's Obligation to Maintain Premises**               | Landlords are required to take reasonable steps to exterminate bed bugs within the rental property                                                                                                         | - Relates to defining landlord/tenant responsibilities;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement |
| Georgia    | **GA. RULES OF DEPT. OF PUBLIC HEALTH 511-6-2-.13, Tourist Accommodations - Insect and Rodent Control** | Effective and appropriate measures shall be taken to eliminate the presence of rodents and flies, roaches, bed bugs, and other insects on the premises.                                                          | - Relates to tourist accommodations;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement |
<table>
<thead>
<tr>
<th>State</th>
<th>Citation &amp; Title</th>
<th>Summary</th>
<th>TMA Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illinois</td>
<td><a href="#">610 ILL. COMP. STAT. 85/1 to 85/4, Railroad Sanitation Act</a></td>
<td>No owner or operator of a railroad shall permit any railroad car to be dispatched for the transportation of or occupation by passengers unless such cars are in a clean and sanitary condition and is free from cockroaches, body lice, bedbugs and other vermin.</td>
<td>- Relates to railcars</td>
</tr>
<tr>
<td>Iowa</td>
<td><a href="#">IOWA ADMIN. CODE § 138.13, Migrant Labor Camps - Conditions for Permit</a></td>
<td>In migrant labor camps effective measures shall be taken to control bedbugs within the camp premises.</td>
<td>- Relates to migrant labor camps</td>
</tr>
<tr>
<td>Kansas</td>
<td><a href="#">KAN. ADMIN. REGS. § 4-27-2, Lodging Establishments - Definitions</a></td>
<td>Defines Bed Bugs as an &quot;imminent health hazard&quot;.</td>
<td>- Relates to lodging establishments</td>
</tr>
<tr>
<td></td>
<td><a href="#">KAN. ADMIN. REGS. § 4-27-5, Lodging Establishments - Imminent Health Hazard</a></td>
<td>Licensees of lodging establishments shall cease operations in areas where an “imminent health hazard” has been found and notify Secretary of Agriculture within 12 hours.</td>
<td>- Only specifies reporting for lodging establishments not private residences; - Assigns reporting responsibility to Sec. of Agriculture (not state health dept.)</td>
</tr>
<tr>
<td></td>
<td><a href="#">KAN. ADMIN. REGS. § 4-27-9, Lodging Establishments - Guest Rooms</a></td>
<td>No guest room that is infested by insects, rodents, or other pests shall be rented until the infestation is eliminated. The presence of bed bugs, which is indicated by observation of a living or dead bed bug, bed bug carapace, eggs or egg casings, or the typical brownish or blood spotting on linens, mattresses, or furniture, shall be considered an infestation. The presence of bed bugs shall be reported to the secretary of Agriculture within one business day upon discovery or upon receipt of a guest complaint. All infestations shall be treated by a licensed pest control operator.</td>
<td>- Only specifies reporting for lodging establishments not private residences; - Assigns reporting responsibility to Sec. of Agriculture (not state health dept.)</td>
</tr>
<tr>
<td>Maine</td>
<td><a href="#">ME. REV. STAT. ANN. tit. 14 § 6021-A, Rental Property - Treatment of Bedbug Infestation</a></td>
<td>Defines landlord and tenant duties with regards to bed bugs an also provides available remedies.</td>
<td>- Relates to defining landlord/tenant responsibilities</td>
</tr>
<tr>
<td>State</td>
<td>Citation &amp; Title</td>
<td>Summary</td>
<td>TMA Comments</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Michigan</td>
<td><strong>MICH. ADMIN. CODE r. 400.57, Family Services Administration Inspection and Licensing - County Infirmaries Care of Residents</strong></td>
<td>Requires county infirmaries to implement procedures to prevent and treat bedbug infestations.</td>
<td>- Relates to county infirmaries</td>
</tr>
<tr>
<td>Minnesota</td>
<td><strong>MINN. R. 4625.1700, Lodging Establishments - Insect and Rodent Control</strong></td>
<td>Every hotel, motel, lodging house, and resort shall be so constructed and equipped as to prevent the entrance, harborage, or breeding of, bedbugs. The commissioner may order the facility to hire an exterminator licensed by the state to exterminate pests when: 1.) the infestation is so extensive that it is unlikely that a nonprofessional can eradicate the pests effectively; or 2.) the extermination method of choice can only be carried out by a licensed exterminator; and 3.) upon reinspection, it is found that an establishment has not been brought into compliance with a prior order to rid the establishment of pests.</td>
<td>- Relates to lodging establishments; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td></td>
<td><strong>MINN. R. 4665.2300, Supervised Living Facilities, Insect and Rodent Control</strong></td>
<td>Every facility shall be so constructed or equipped as to prevent the entrance, harborage, or breeding of flies, roaches, bedbugs, rats, mice, and all other insects and vermin. Cleaning, renovation, or fumigation by licensed pest control operators for the elimination of such pests shall be used when necessary.</td>
<td>- Relates to all insects; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>Nebraska</td>
<td><strong>25 NEB. ADMIN. CODE § Chap.2 - 005.02B(A)(a), Structural Health Related Pest Control</strong></td>
<td>Insects and other pests that create health issues for humans and pets such as vector diseases, bed bugs, and fleas may involve outdoor applications for those pests on individual property. Applicators must demonstrate practical knowledge of environmental conditions particularly related to this activity, since outdoor applications can carry off-site by drift or runoff. Applicators shall demonstrate knowledge of the risks involved with handling and use of pesticides used indoors and in conjunction with structural pest control, and the appropriate application equipment to be used.</td>
<td>- Relates to all insects; - No reporting requirements;</td>
</tr>
<tr>
<td>State</td>
<td>Citation &amp; Title</td>
<td>Summary</td>
<td>TMA Comments</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Nebraska</td>
<td>175 NEB. ADMIN CODE § Chap. 2 - 004.12, Developmentally Disabled Facilities</td>
<td>Every facility shall or equipped so as to prevent the entrance, harborage, or breeding of flies, roaches, bedbugs, rats, mice, and all other insects and vermin. Cleaning renovation, or fumigation by licensed pest control operator for the elimination of such pests shall be used when necessary.</td>
<td>- Relates to all insects; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>Nevada</td>
<td>NEV. REV. CODE § 447.030, Hotel Rooms - Extermination of Vermin</td>
<td>Any room in any hotel in this state which is or shall be infested with vermin or bedbugs or similar things shall be thoroughly fumigated, disinfected and renovated until such vermin or bedbugs or other similar things are entirely exterminated.</td>
<td>- Relates to hotels; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td></td>
<td>NEV. ADMIN. CODE § 444.552, Labor Camps - General Standards&quot;</td>
<td>Effective measures must be taken to control rats and flies, mosquitoes, bedbugs and other insects or parasites within the camp premises.</td>
<td>- Relates to labor camps; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>N.H. REV. STAT. ANN. § 48-A:11, Housing Standards - Minimum Standards</td>
<td>Any municipality may enact, in the sections of their housing codes dealing with infestations of insects, provisions directed at the unique problems posed by infestations of bed bugs, provided that such provisions are no less protective of the residents of dwelling units in which bed bug infestations are found than are the provisions dealing with infestations of other kinds of insects.</td>
<td>- No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td></td>
<td>N.H. REV. STAT. ANN. § 48-A:14, Housing Standards - Minimum Standards Landlord</td>
<td>No Landlord shall rent the premises if it is infested by bed bugs and the landlord is not conducting a periodic inspection and remediation program. In this paragraph &quot;remediation&quot; means action taken by the landlord that substantially reduces the presence of bed bugs in a dwelling unit for a period of at least 60 days; The lessor or owner of non-restricted property may terminate any tenancy by giving to the tenant or occupant a notice in writing to quit the premises if the tenant willful failure by the tenant to prepare the unit for remediation of an infestation of insects or rodents, including bed bugs, after receipt of reasonable written notice of the required preparations and reasonable time to complete them.</td>
<td>- Relates to defining landlord/tenant responsibilities; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>State</td>
<td>Citation &amp; Title</td>
<td>Summary</td>
<td>TMA Comments</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------</td>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td>N.H.</td>
<td>N.H. REV. STAT. ANN. § 540:2, Termination of Tenancy</td>
<td>The lessor or owner of non-restricted property may terminate any tenancy by giving to the tenant or occupant a notice in writing to quit the premises if the tenant willful failure by the tenant to prepare the unit for remediation of an infestation of insects or rodents, including bed bugs, after receipt of reasonable written notice of the required preparations and reasonable time to complete them.</td>
<td>- Relates to defining landlord/tenant responsibilities; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td></td>
<td>N.H. REV. STAT. ANN. § 540:13-e, Bed Bug Remediation Liability</td>
<td>The landlord shall bear the reasonable costs of remediation of an infestation of bed bugs but may recover those costs if the tenant is responsible for the infestation.</td>
<td>- Relates to defining landlord/tenant responsibilities; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td></td>
<td>N.H. REV. STAT. ANN. § 540-A:3, Landlord Prohibited Acts</td>
<td>No landlord shall willfully fail to investigate a tenant's report of an infestation of insects, including bedbugs</td>
<td>- Relates to defining landlord/tenant responsibilities; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>New York</td>
<td>N.Y. CITY ADMIN. CODE § 27-2018.1, Notice of bed bug infestation history</td>
<td>For housing accommodations subject to this code, an owner shall furnish to each tenant signing a vacancy lease, a notice in a form promulgated or approved by the state division of housing and community renewal that sets forth the property's bedbug infestation history for the previous year regarding the premises rented by the tenant and the building in which the premises are located.</td>
<td>- Relates to defining landlord/tenant responsibilities; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td></td>
<td>N.Y. EDUC. LAW § 920 (McKinney), Public Schools - Infestation of Bed Bugs</td>
<td>Public schools; infestation of bedbugs (Cimex lectularius). In a city school district having a population of one million or more inhabitants, the principal of each public school shall provide immediate notification to all parents or persons in parental relation disclosing a finding relating to the infestation of bedbugs (Cimex lectularius) in such school.</td>
<td>- Relates to public schools; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>Ohio</td>
<td>OHIO REV. CODE ANN. § 3731.13, Hotels - Bedding, Floors and Carpet Must be Kept Sanitary</td>
<td>All bedding used in any hotel must be thoroughly aired, disinfected, and kept clean. No bedding which is infested with vermin or bedbugs shall be used on any bed in any hotel. All floors, carpets, and equipment in hotels, and all walls and ceilings shall be kept in sanitary condition.</td>
<td>- Relates to hotels; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>State</td>
<td>Citation &amp; Title</td>
<td>Summary</td>
<td>TMA Comments</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Oregon</td>
<td>OR. REV. STAT. § 570.880, Confidentiality of Bed Bug Infestation Report</td>
<td>The location, occupier identity, and detailed facts of a bed bug infestation reported to an agency shall remain confidential.</td>
<td>- No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td></td>
<td>OR. ADMIN. R. 333--030-0070, Campgrounds - Insect and Rodent Control</td>
<td>Campground buildings and structures must be maintained and cleaned to prevent bed bug infestations.</td>
<td>- Relates to campgrounds; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>7 PA. CODE § 82.15, Seasonal Farm Labor Camps - Insect Rodent Control</td>
<td>Effective control measures and environmental changes approved by the Department shall be taken to prevent or eliminate infestation by and harborage of animal or insect vectors to include rodents, flies, mosquitoes, bedbugs, cockroaches, lice and other pestiferous insects.</td>
<td>- Relates to farm labor camps; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>25-3 R.I. CODE R. § 24:7, Categories for Commercial Applicators</td>
<td>Specifically includes “bed bugs” in the definition of pesticide applicators who use restricted use pesticides.</td>
<td>- No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>South Dakota</td>
<td>S.D. ADMIN. R. 44:02:08:05, Vacation Homes - Vermin Control</td>
<td>A vacation home establishment must be constructed, equipped, and maintained to prevent the entrance, harborage, or breeding of flies, roaches, rats, mice, bed bugs, and all other insects and vermin. Specific means necessary for the elimination of such pests, such as cleaning, renovation, or fumigation, must be used. The department may require the facility to hire a professional exterminator to exterminate pests</td>
<td>- Relates to vacation homes; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>State</td>
<td>Citation &amp; Title</td>
<td>Summary</td>
<td>TMA Comments</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Texas</td>
<td>TEX. HEALTH &amp; SAFETY CODE ANN. § 341.011, Nuisances and General Sanitation</td>
<td>The presence of bedbugs is considered a public health nuisance and a person shall be required to abate the nuisance when it is known.</td>
<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td>W.VA. CODE R. § 16-6-16, Hotels and Restaurants - Bed Bugs</td>
<td>In every hotel, any room infected with vermin or bedbugs shall be fumigated, disinfected and renovated until said vermin or bedbugs are exterminated.</td>
<td>- Relates to hotels and restaurants; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>WIS. ADMIN. CODE DEPT. OF HEALTH SERV. § 190.08, Institution Sanitation - Pest Control</td>
<td>Establishes standards of hygiene and safety in institutions that house orphans, indigents and delinquents. Concerning eradication, all means necessary shall be taken for the elimination of rodents, flies, roaches, bedbugs, fleas, lice and other household pests shall be used. Extreme care shall be taken in the use of poison to prevent accidental poisoning of domestic animals and people.</td>
<td>- Relates to specific housing institutions; - Not unique to bedbugs; - No reporting requirements; - No mention of physician involvement</td>
</tr>
</tbody>
</table>
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 301
2021

Subject: Access to Direct-Acting Antiviral Therapy for Texas Medicaid Beneficiaries Infected With Hepatitis C (Tabled Res 310 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Hepatitis C virus (HCV) is a bloodborne pathogen that left untreated causes liver cirrhosis and hepatocellular carcinoma in the majority of those with chronic infection; and

Whereas, In Texas, 217,500-325,000 people are infected with HCV; and

Whereas, Texas has one of the highest hepatocellular cancer incidence rates in the country, and HCV is the second leading cause of this cancer; and

Whereas, As of 2017, HCV was a leading cause of liver transplants in the United States; and

Whereas, HCV is part of Healthy People 2030, an initiative to eradicate certain diseases; and

Whereas, Combined private and public funding has resulted in the development of direct-acting antiviral (DAA) therapies, which work to inhibit HCV cellular processes that result in liver disease; and

Whereas, DAA therapies have a greater than 90% cure rate and are an essential tool in eradicating this disease; and

Whereas, In Texas, more than 4 million people rely on Texas Medicaid for access to health care; and

Whereas, Texas Medicaid rules require that HCV-infected beneficiaries demonstrate irreparable, advanced liver fibrosis to be eligible for DAA therapy, a requirement that is the primary barrier to a beneficiary’s receiving the therapy; and

Whereas, Texas Medicaid beneficiaries are increasingly ineligible for patient-assistance programs, which provide DAA therapy free of charge only to certain low-income populations; and

Whereas, Withholding this cure results in a cycle of continued transmission, liver-cancer incidence, and thus demand for liver transplants statewide; and

Whereas, This is cost ineffective because not only is the average billing for a single liver transplant approximately $900,000 (more than 20 times the cost of DAA therapy) but also the human cost for not eradicating this curable disease is incalculable; therefore be it
RESOLVED, That the Texas Medical Association adopt the following language as policy:

The Texas Medical Association supports and will advocate for removing the requirement that a Texas Medicaid beneficiary infected with hepatitis C virus have liver fibrosis before being eligible to receive direct-acting antiviral therapy.

**Relevant TMA Policy:**

1. 190.002 Medicaid Medications
2. 190.011 Medicaid Benefits
3. 190.023 Policy Principles for Medicaid and CHIP Legislative Initiatives
4. 260.060 Hepatitis C

**Relevant AMA Policy:**

1. Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845

**References:**

Subject: Advocating for the Improvement of Access to Mental Health Services Among Minority Teens (Tabled Res 311 2021)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, An estimated 10% to 20% of adolescents worldwide experience mental health conditions, which go underdiagnosed and undertreated; and

Whereas, Adolescents with mental health conditions are more vulnerable to social exclusion, discrimination, stigma, educational difficulties, risk-taking behaviors, physical illness, and human rights violations; and

Whereas, A 2007 Youth Risk Behavior Survey by the Centers for Disease Control and Prevention found significantly higher prevalence of sad mood, suicidal ideation, and suicidal attempts among Latino and African American youth compared with non-Hispanic whites; and

Whereas, Only 1.5% of minority youth receive mental health care, compared with 3.5% of ethnic majority youth; and

Whereas, Stigma and cultural norms regarding mental health represent significant barriers to mental health treatment in adolescents; and

Whereas, Culturally appropriate mental health services show the most promise for reducing major barriers to access and utilization, particularly language- and ethnicity-matching between patients and the mental health professionals who treat them; and

Whereas, Minority populations are underrepresented in health care professions, and those who provide care are less likely to be board certified than health care professionals who treat white patients; and

Whereas, School-based mental health centers can address significant barriers that limit access to mental health care by providing services in the setting where students spend much of their time; and

Whereas, A 2018 meta-analysis suggests child psychiatrists and other mental health professionals are wise to recognize the important role school personnel, who are naturally in children’s lives, can play in decreasing mental health problems in youth; and

Whereas, Only 34% of teachers believed they had the skills to support the mental health needs of students in their classrooms; and

Whereas, Students experiencing mental health challenges were more likely to be labeled as “bad students”, and exclusionary discipline rates are significantly higher for students of color and students in special education classrooms; and
Whereas, Research indicates individuals possess explicit biases that individuals with mental illness are helpless and bad but not blameworthy, which conflict with their implicit biases that individuals with mental illness are helpless, bad, and blameworthy; and

Whereas, Everyone harbors implicit biases, and these biases influence every aspect of society; however, people can “unlearn” implicit biases, once the biases are identified; and

Whereas, As mental health disparities are addressed, identifying interventions to achieve the greatest positive mental health outcome among minority teens remains an area for research and evaluation; and

Whereas, Texas Health and Human Services supports the use of the Child and Adolescents Needs and Strength Assessment, one of the few existing assessment tools, as an effective tool to provide metrics on trauma-informed behavioral and mental health needs within the state; and

Whereas, The use of culturally appropriate methodology is most effective to yield conclusive results for cross-cultural research; and

Whereas, Current Texas Medical Association policy advocates for school-based mental health services that provide an integrated system of educator training, referral to treatment, and clear access to health care professionals; and

Whereas, Current American Medical Association policy recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk youths have access to appropriate mental health screening and treatment services, and that support efforts to accomplish these objectives; and

Whereas, Current AMA policy supports working with the U.S. Department of Education and state education boards and encourages them to adopt basic mental health education designed for preschool through high-school students, as well as for their parents, caregivers, and teachers; therefore be it

RESOLVED, That TMA advocate for culturally informed mental health outreach and services to increase utilization by minority youth in schools, including increasing the number of minority mental health professionals; and be it further

RESOLVED, That TMA advocate for school districts to incorporate best practices to reduce biases, including those against minority students facing mental health and behavioral disorders; and be it further

RESOLVED, That TMA advocate for increased data collection of mental health intervention outcomes among minority adolescents.

Relevant TMA Policy:
55.033 Children’s Mental and Behavioral Health
215.023 Identifying Trauma and Mental Health Susceptibilities in Schools
265.018 Evidence-Based Medicine and Practice

Relevant AMA Policy:
D-345.994 Increased Detection of Mental Illness and Encouraging Education
H-60.991 Providing Medical Services through School-Based Health Program
H-345.977 Improving Pediatric Mental Health Screening
References:


Subject: Designating Texas Hospitals as Sensitive Locations (Tabled Res 315 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Undocumented immigrants are concerned they will face legal action, such as deportation, when they visit hospitals to receive care for themselves or their family members; and

Whereas, Fear of legal action against immigrants may lead to poor control of diseases that necessitate hospital emergency visits, thus increasing the financial burden of preventable hospitalizations; and

Whereas, Sensitive patient information is protected under the Health Insurance Portability and Accountability Act, which inhibits disclosure of such information except in rare circumstances; and

Whereas, Texas Medical Association policy advocates that children “be able to receive nonemergency and preventive care and supports health care professionals delivering medical care to children regardless of immigration status” (Policy 55.057); and

Whereas, Latina women, regardless of immigration status, are less likely to use health services for themselves and their children when immigration laws are enforced in health care facilities; and

Whereas, Undocumented parents are less likely to seek care for their children, even if their children have citizenship, when they fear they will be asked to provide documentation of citizenship; and

Whereas, U.S. Immigration and Customs Enforcement (ICE) designates hospitals as sensitive locations where enforcement actions are not to occur; and

Whereas, Undocumented immigrants receiving medical care at hospitals have reported ICE activities such as interrogations and arrests, despite ICE policy to not operate at hospitals; and

Whereas, American Medical Association policy encourages hospitals to “promote their status as sensitive locations” and opposes the presence of ICE enforcement (Policy D-160.921); and

Whereas, After the 2019 mass shooting in El Paso, authorities reported concern some undocumented immigrants did not seek care for traumatic injuries at hospitals out of fear of deportation; therefore be it

RESOLVED, That the Texas Medical Association oppose U.S. Immigration and Customs Enforcement operations in hospitals; and be it further

RESOLVED, That TMA advocate for state legislation designating hospitals as sensitive locations where U.S. Immigration and Customs Enforcement cannot operate; and be it further,

RESOLVED, That TMA encourage hospitals to publicize their status as sensitive locations.
Relevant TMA policy:
55.057 Health Care of Undocumented Children

Relevant AMA policy:
D-160.921 Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution 304
2021

Subject: Updating Texas Medical Association Teenage Sexual Health Guidelines
(Tabled Res 318 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The U.S. has one of the highest teen pregnancy rates among developed nations; and

Whereas, Texas has one of the highest teen pregnancy rates in the U.S.; and

Whereas, Rates for many sexually transmitted diseases have risen among younger age groups in Texas; and

Whereas, The percentage of Texas high-school students who have had sexual intercourse is equal to the national average; and

Whereas, The American Academy of Pediatrics supports “evidence-based education about human sexuality,” and states that sexuality education has been shown to reduce the risk of pregnancy and sexually transmitted infections among adolescents; and

Whereas, The American Academy of Family Physicians explicitly opposes abstinence-only sexual education, instead promoting sexual health education that is evidence-based, includes comprehensive and effective community programs, and “recognizes the importance of comprehensive sex education in reducing the incidence of unintended teenage pregnancies; preventing sexual assault; [and] increasing awareness of the risks and signs in adolescents regarding sex trafficking;” and

Whereas, American Medical Association policy opposes “the sole use of abstinence-only education” (Policy H-170.968); therefore be it

RESOLVED, That the Texas Medical Association encourage its members to engage with their local communities and school boards to develop comprehensive sexual education programs for adolescents that teach more than abstinence as an effective practice to reduce the risk of unintended pregnancy or sexually transmitted infections; and be it further

RESOLVED, That TMA amend Policy 55.016 Sexuality Education to:

TMA should promote, through visible and vocal leadership to the state and other interested organizations and associations, its policy advocating comprehensive programs in sexuality education.

TMA will act as a resource and clearinghouse for scientific, medically accurate information on adolescent sexuality, dispelling medical misinformation, and for information on sexuality education programs; offer recommendations to state and local governmental agencies and other
interested organization based on scientific, medically accurate information on adolescent sexuality, dispelling medical misinformation.

TMA will continue to work with the Texas Education Agency and the state legislature to develop and implement curricula on sexuality education, e.g., education for self-responsibility.

TMA will monitor and encourage research on the effectiveness of different sexuality curricula. TMA will actively seek community, business, and corporate support for this policy.


Related TMA Policy:
55.016 Sexuality Education

Relevant AMA Policy:
H-170.968 Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 305
2021

Subject: Supporting an Opt-Out Organ, Eye, and Tissue Donation System in Texas
(Tabled Res 319 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Texas employs an opt-in organ donation system where donors must actively register or agree to become a donor, while opt-out or presumed consent systems make organ donation automatic unless the individual specifically requests his or her organs are not donated; and

Whereas, Texans currently have the option to register voluntarily to become an organ, eye, and tissue donor through the online Donate Life Texas Registry, or opt-in to the registry when applying for or renewing their driver’s license, hunting license, identification card, or vehicle registration, or use the MedID tab in the iPhone Health App (iOS 10 or later); and

Whereas, In the U.S., 95% of adults support organ donation, while only 58% are signed up to donate; and

Whereas, Texas has around 12 million registered donors despite having approximately 21.5 million residents over the age of 18; and

Whereas, More than 113,000 men, women, and children are on the national transplant waiting list; and

Whereas, Nationally 20 people die daily waiting for a transplant; and

Whereas, Approximately 1,500 Texans are removed annually from the transplant waiting list due to death or becoming too ill; and

Whereas, Despite some opposition in Texas to an opt-out system due to concerns it would decrease current donor rates, countries with an opt-out system such as Spain, Croatia, and Belgium have higher actual donation rates than the U.S.; and

Whereas, During the 2017 Texas legislative session, the Texas Medical Association testified in favor of House Bill 1938 that would have changed Texas from an opt-in to an opt-out system; therefore be it

RESOLVED, That TMA adopt new policy to support an opt-out organ, eye, and tissue donation system in Texas; and be it further

RESOLVED, That TMA amend Policy 280.010 Physician Role in Promoting Organ and Tissue Donation and Transplantation to include this language.

Related TMA Policy:
280.010 Physician Role in Promoting Organ and Tissue Donation and Transplantation
45.008 Blood Donations and Transfusions
Related AMA Policy:

1. Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool H-370.958
2. Organ Donation and Honoring Organ Donor Wishes H-370.998
3. Methods to Increase the US Organ Donor Pool H-370.959
4. Organ Donor Recruitment H-370.995
5. Organ Donor Recruitment H-370.996
6. Organ Donation D-370.985

References:

5. Goard A. Texas bill aims to make organ donation opt-out, sparking debate. KXAN Austin. April 27, 2017.
Subject: Maternal Health and Postpartum Depression Screening (Tabled Res 320 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, A recent meta-analysis shows 12% of women who give birth experience postpartum depression; and
Whereas, Women who participate in depression screenings, with or without treatment, show relevant reductions in postpartum depression; and
Whereas, Women with increased symptoms relatively early in the postpartum period are likely to develop postpartum depression within 18 months and may benefit significantly from early intervention; and
Whereas, Persistent and severe postpartum depressive symptoms in the mother are more likely to raise the risk of adverse child outcomes such as behavioral problems at age 3.5 years (odds ratio [OR], 4.84), lower mathematics grades at age 16 years (OR, 2.65), and higher prevalence of depression at age 18 years (OR, 7.44); and
Whereas, The American College of Obstetricians and Gynecologists recommends obstetrician-gynecologists and obstetric care providers screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized tool, and recognizes that screening can provide clinical benefits, although initiation of treatment or referral to mental health care professionals offers maximum benefit; and
Whereas, American Medical Association policy supports working with stakeholders to encourage implementation of a routine protocol for depression screening in pregnant and postpartum women during prenatal, postnatal, pediatric, or emergency department visits; and
Whereas, AMA encourages the development of training materials related to maternal depression to advise physicians about appropriate treatment and referral pathways; therefore be it

RESOLVED, That the Texas Medical Association encourage implementation of postpartum depression screenings as routine protocol for perinatal and postnatal women in health care settings; and be it further

RESOLVED, That TMA promote education about postpartum depression screenings to primary care physicians who treat perinatal and postpartum women.

Related TMA Policy:
None.
Related AMA Policy:

D-420.991 Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination

H-420.953 Improving Mental Health Services for Pregnant and Postpartum Mothers

References:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 307
2021

Subject: Saving Energy, Reducing Costs, and Increasing Efficiency in Medical Practices
(Tabled Res 321 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, A study by The Commonwealth Fund projected more than $5.4 billion in savings if U.S. hospitals reduced energy consumption and waste, and gained efficiencies in operating room practices; and

Whereas, The U.S. health care industry contributes approximately 10% of the nation’s carbon dioxide emissions; and

Whereas, Switching to copy paper with at least 30% recycled content and setting the default print option to double-sided printing for networked printers reduced University of Wisconsin Hospital and Clinics’ paper use by 25% to 30%, lowering monthly costs by $11,000 to $13,000; and

Whereas, Dell Children’s Medical Center in Austin estimates that by installing fluorescent lights, automatic on- and off-switches, and high-efficiency air conditioning, among other initiatives, it saves enough energy to power, heat, and cool nearly 300 average-size homes daily; and

Whereas, The My Green Doctor initiative, used by medical offices, clinics, and outpatient centers in 58 countries and 38 U.S. states, requires adding only five minutes of Green Team business to each regular practice or clinic planning meeting; and

Whereas, My Green Doctor offers a Meeting-by-Meeting Guide that outlines discussion and decision topics, as well as 50 energy-efficiency action and education steps physicians can consider for their offices; and

Whereas, The Texas Medical Board adheres to a resource efficiency plan to promote energy savings in Texas; and

Whereas, Texas Medical Association policy promotes energy conservation measures for homes, businesses, and public buildings to decrease Texas energy consumption (TMA Policy 260.077); and

Whereas, American Medical Association policy supports physicians in adopting environmental sustainability programs in their practices (AMA Policy H-135.923); and

Whereas, AMA guidelines work to support and educate physicians in implementing programs that help their medical practices save energy, reduce costs, and increase efficiencies; therefore be it

RESOLVED, That the Texas Medical Association adopt and recommend energy conservation guidelines for Texas medical practices; and be it further
RESOLVED, That TMA partner with the My Green Doctor initiative and promote its guidelines to physicians and health care providers in Texas; and be it further
RESOLVED, That TMA promote education for green practices to physicians and health care providers in Texas.

Related TMA Policy:
260.077 Clean Air in Texas

Related AMA Policy:
H-135.923 AMA Advocacy for Environmental Sustainability and Climate

References:
Whereas, Firearm violence is a public health issue in the U.S., given that it is responsible for the deaths of 36,000 Americans each year (an average of 100 per day), is one of the top three causes of death among American youth, and costs the U.S. at least $174 billion annually; and

Whereas, Texas Medical Association policy recognizes firearm violence as a public health issue requiring the promotion of evidence-based strategies in Texas (TMA Policy 260.015); and

Whereas, More than half (60%) of all suicides in Texas in 2016 were by firearm, and the firearm suicide rate in Texas increased 18% from 2006 to 2016; and

Whereas, More than three-quarter (78%) of veteran suicides in Texas in 2017 were by firearm; and

Whereas, Mass shootings are defined as those in which the perpetrator took the lives of at least four people, excluding the shooter; and

Whereas, The 417 mass shootings in 2019, including the deadliest one of the year in El Paso, exceeded the number of days in the year; and

Whereas, Accessibility to firearms increases the risk for completed suicide and for becoming a victim of homicide; and

Whereas, Texas currently has no mandated waiting period for firearm purchases; and

Whereas, Waiting periods require a number of days to pass between when a buyer purchases a firearm and then takes possession of that firearm; and

Whereas, Waiting periods can provide a “cooling period” where visceral factors, such as anger or suicidal impulses, that otherwise could spur people to inflict harm on others or themselves can pass; and

Whereas, American Medical Association policy advocates a waiting period and encourages legislation that enforces a waiting period for firearm purchasers (AMA Policy H-145.996); and

Whereas, States with mandatory waiting periods – no matter the length – had, on average, 17% fewer homicides and 10% fewer suicides; therefore be it

RESOLVED, That the Texas Medical Association advocate for mandatory waiting periods following the purchase of firearms to reduce firearm-related injuries and deaths.
Related TMA Policy:

260.015 Firearms

Related AMA Policy:

D-145.995 Gun Violence as a Public Health Crisis
H-145.996 Firearm Availability
H-145.984 Data on Firearm Deaths and Injuries

References:

10. Luca M., Malhotra D, Poliquin C. Handgun waiting periods reduce gun deaths. PNAS. 2017 Nov;114(46), 12162-12165.
Subject: Promoting and Improving Health Literacy (Tabled Res 325 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The National Assessment of Adult Literacy found that 88% of American adults are “not proficient” in health literacy; and

Whereas, Texas has a lower rate of health literacy than many other states; and

Whereas, Those with limited health literacy often have difficulty with or an inability to perform simple health-related tasks; and

Whereas, Lower health literacy is associated with physical inactivity, unhealthy diet, unhealthy weight, decreased engagement with health care professionals, and poorer health outcomes overall; and

Whereas, The direct cost of low health literacy in the U.S. is $105 billion to $238 billion every year; and

Whereas, Various Texas cities have begun initiatives to improve health literacy, such as the San Antonio Health Literacy Coalition; and

Whereas, Current American Medical Association policy recognizes and provides recommendations to alleviate the challenges of low community health literacy (H-160.931); and

Whereas, The Texas Medical Association has a webpage dedicated to community health literacy but as of yet does not have a comprehensive policy on the topic; therefore be it

RESOLVED, That the Texas Medical Association recognize inadequate patient health literacy is a barrier to effective medical diagnosis and treatment; and be it further

RESOLVED, That TMA recommend the adoption of a health literacy policy at all health care institutions that should aim to improve communication by physicians and other health care professionals, and improve educational approaches to patient visits; and be it further

RESOLVED, That TMA encourage the allocation of public and private funds for research about health literacy, as well as the development of low-cost community and health system resources focused on improving health literacy.

Related TMA Policy:
260.037 Essential Public Health Services
165.005 Public School Finance and Taxes

Related AMA Policy:
Health Literacy H-160.931
1 Early Literacy Programs H-60.914

2

3 References:
4 1. White S. Assessing the Nation’s Health Literacy Key concepts and findings of the National
7 3. Aaby A, Friis K, Christensen B, Rowlands G, Maindal HT. Health literacy is associated with health
8 behaviour and self-reported health: A large population-based study in individuals with cardiovascular
WHEREAS, The teenage birth rate in the U.S. remains among the highest in the developed world; and
WHEREAS, Approximately 19% of sexually active women aged 15 to 19 in the U.S. became pregnant; and
WHEREAS, A 2016 study conducted by the U.S. Department of Health and Human Services revealed that the adolescent birthrate in Texas is around 31 per 1,000 teenage females aged 15 to 19, which is nearly 11 points higher than the national average; and
WHEREAS, The same 2016 study found that 19% of adolescent pregnancies in Texas were repeat births compared with only 16% of adolescent pregnancies in the U.S. as a whole; and
WHEREAS, Of the approximately 574,000 adolescent pregnancies that occur each year in the U.S., 75% are unintended; and
WHEREAS, A 2013 study revealed that approximately one in three adolescents reported using either a least effective contraceptive method (15.7%) such as the withdrawal method, condoms, or the contraceptive sponge, or no contraceptive method (17.2%) following their first live birth; and
WHEREAS, Postpartum adolescents who participated in a comprehensive, multidisciplinary maternity program who were given a long-acting reversible contraceptive demonstrated a markedly more reduced repeat adolescent pregnancy rate than those who did not; and
WHEREAS, The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics both recommend that clinicians counsel women (including adolescents) during prenatal care about birth spacing and postpartum contraceptive use, including the safety and effectiveness of long-acting reversible methods that can be initiated immediately postpartum; and
WHEREAS, Long-acting reversible contraceptives are proven to be an effective method for this chosen demographic partially because they do not require regular action on the part of the adolescent; and
WHEREAS, 84% of postpartum adolescent women demonstrate a high 12-month continuation of long-acting reversible contraceptive methods; and
WHEREAS, In Texas, the current age to consent to sexual intercourse is 17 years old, while the age to obtain prescriptive contraceptives and other sexual health services is 18 years old, thus creating a gap in adolescent sexual health care within the state; and
Whereas, Texas and Utah are the only two states in the nation where adolescent mothers must receive 
parental consent to request prescriptive birth control, including long-acting reversible contraceptives, 
from a physician or provider; and

Whereas, 27 states and the District of Columbia explicitly allow all individuals, including minors, to 
consent to contraceptive services; and

Whereas, The state of Texas provides free and reduced-cost access to long-acting reversible 
contraceptives, among other services, to low-income women through Healthy Texas Women and the 
Texas Family Planning Program, including to minors who lose Children’s Health Insurance Coverage 
coverage; and

Whereas, Under federal laws, minors can receive confidential family planning services without parental 
consent through clinics that qualify for Title X funding and through Medicaid; and

Whereas, Across the nation, clinics receiving Title X funding have withdrawn from the program due to 
new regulations and stipulations, leaving a gap in family planning services, especially for low-income 
families; and

Whereas, For women and adolescents with little to no contraceptive coverage, the up-front cost of long-
acting reversible contraceptives and the insertion procedure is often prohibitive; and

Whereas, Adolescent pregnancies cost the state of Texas approximately $1.1 billion each year due to loss 
of wages and increased reliance on social services; and

Whereas, Current American Medical Association policy recognizes the efficacy of long-acting reversible 
contraceptives immediately postpartum; and

Whereas, Current Texas Medical Association policy supports statewide efforts to improve access to 
family planning services for women in need, including long-acting reversible contraceptives; and

Whereas, Current TMA policy supports the right to confidential care for unemancipated minors; therefore
be it

RESOLVED, That our Texas Medical Association support increased funding for long-acting reversible 
contraceptives and other prescriptive contraceptives for women who do not qualify for services under 
Healthy Texas Women and the Texas Family Planning Program and who do not have reliable access to 
Title X-funded clinics; and be it further

RESOLVED, That our TMA support and advocate for the reduction of the age in Texas at which a minor 
can access prescriptive contraceptives, including long-acting reversible contraceptives, without parental 
consent from either (a) 18 to 17, to match the Texas age of consent, or (b) 18 to 15, to accommodate the 
entire age group of adolescents who are at increased risk of teenage pregnancy within the state; and be it 
进一步

RESOLVED, That our TMA advocate for the expansion of the Texas “mature minor” doctrine described 
in TMA Policy 55.004 Adolescent Sexual Activity to include access to contraceptive options, such as 
prescriptive birth control methods (e.g., oral contraceptives, shots, and intrauterine devices), and sexual 
health services (e.g., pap smears and treatment for urinary tract infections) without parental consent.
Related TMA Policy:
1. 55.004 Adolescent Sexual Activity
2. 330.015 Physician-Led Initiatives to Address Maternal Mortality and Morbidity
3. 260.075 Preventive Health Care for Texas Women

Related AMA Policy:
6. Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement H-75.984
7. Coverage of Contraceptives by Insurance H-180.958
8. Reducing Unintended Pregnancy H-75.987

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution 311
2021

Subject:   Lowering the Legal Age for Minors to Access Contraceptive Services
(Tabled Res 328 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, In Texas, the current age of consent to sexual acts is 17-years-old, while the age to obtain contraceptives without required parental consent is 18-years-old, unless the minor receives Title X services or Medicaid; and

Whereas, As a result of revisions to Title X regulations, major organizations are opting out of Title X; for example, Planned Parenthood, the largest single provider of Title X services in the U.S., announced its decision to withdraw from the program, which will decrease minors’ access to contraceptive services; and

Whereas, In Texas, the teen birth rate in 2016 for mothers aged 15 to 17 was 15.1 births per 1,000 girls compared with the U.S. teen birth rate of 8.8 births for that age range, making Texas the seventh highest state for teen pregnancies; and

Whereas, In Texas, 38% of high school females reported having had sexual intercourse in 2017; and

Whereas, Fourteen percent of high school students in Texas reported they or their partner used birth control pills before their last sexual intercourse, while 23% of high school students in Texas reported they or their partner did not use any method to prevent pregnancy during last sexual intercourse – compared with the U.S. averages of 21% and 14%, respectively; and

Whereas, Twenty-seven states and the District of Columbia adopted state laws that permit minors to consent to contraception without parental notification; and

Whereas, TMA policy states that requiring parental involvement in sexual and contraceptive health care reduces access to care without reducing sexual activity or increasing communication between parents and teens; and

Whereas, TMA legislative initiatives have advocated for adoption in state statute of the “mature minor” doctrine and elimination of other statutory barriers to adolescents accessing health care; and

Whereas, American Medical Association policy encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws that restrict the availability of confidential care; therefore be it

RESOLVED, That the Texas Medical Association support lowering the legal age at which a minor can access contraceptives without a guardian or parental consent to at least age 17; and be it further

RESOLVED, That TMA continue to support initiatives, programs, and funding that eliminate barriers to adolescents accessing reproductive health care.
Related TMA Policy:
55.035 Right to Confidential Care
55.004 Adolescent Sexual Activity
55.016 Sexuality Education

Related AMA Policy:
Opposition to HHS Regulations on Contraceptive Services for Minors H-75.998:
Confidential Health Services for Adolescents H-60.965

References:
Subject: Advocating Against Electronic Nicotine Delivery Systems (ENDS)  
(Tabled Res 301 2020)

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Science and Public Health

Whereas, The Food and Drug Administration (FDA) has acknowledged that consumers of e-cigarette and vape products currently have no way of knowing whether e-cigarettes and other electronic nicotine delivery systems (ENDS) are safe or how much nicotine or other potentially harmful chemicals they inhale when using them; and

Whereas, FDA found that e-cigarettes and other ENDS contain various toxins, carcinogens, and components suspected of being harmful to humans; and

Whereas, E-cigarettes and other ENDS contain nicotine, a highly addictive drug and has immediate biochemical effects on the brain and body; and

Whereas, According to the Centers for Disease Control and Prevention (CDC), phone calls to poison control centers related to toxic levels of nicotine exposure from e-cigarettes and other ENDS increased more than 14-fold since 2011; and

Whereas, Manufacturers and distributors of e-cigarettes claim they are an effective and healthy alternative to tobacco smoking since the user does not inhale harmful tobacco smoke, which contains well more than 4,000 toxic chemicals; and

Whereas, CDC reports that e-cigarette and other ENDS use among students in grades 6-12 tripled in one year and are the most commonly used tobacco products among youth; and

Whereas, The Cochrane study published in December 2014 shows minimal effectiveness of e-cigarettes in smoking cessation; and

Whereas, Many retail “health” clinics sell e-cigarettes in the same facility where they counsel patients about healthy lifestyle choices; and

Whereas, The American Academy of Family Physicians (AAFP) Tar Wars program was revamped in 2019 to include information on e-cigarette use and use prevention; and

Whereas, AAFP and other specialty societies already have developed physician education tools; therefore be it

RESOLVED, That the Texas Medical Association educate its members on the various aspects of e-cigarette use through ongoing CME and articles in Texas Medicine Today; and be it further
RESOLVED, That TMA advocate for legislation that bans the sale of flavored, mint, and menthol tobacco products including both e-cigarette products and combustible products; and be it further

RESOLVED, That TMA advocate against social media companies using influencers to advertise electronic nicotine delivery systems; and be it further

RESOLVED, That TMA advocate against the sale of e-cigarettes and their component products and accoutrements at retail clinics.

Related TMA Policy:
None.

Related AMA Policy:
H-495.986 Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes
D-495.992 Legal Action to Compel FDA to Regulate E-Cigarettes
H-495.988 FDA Regulation of Tobacco Products
Subject: Elimination of Human Abuse and Persecution (Tabled Res 302 2020)

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Science and Public Health

Whereas, Cultures of the East and West alike have long recognized that a healthy mind promotes a healthy body as exemplified by the sayings “Swastha mun swastha shareer” (Sanskrit) and “Mens sana in corpore sano” (Latin); and

Whereas, Various forms of physical, mental, and sexual abuse and torture are often used by one human being or a group to persecute another human being or a group, with the goal of coercing the other person or group (victim or victims) to act in a manner that yields various financial, religious, political, or countless other personal or collective gains to the persecutor(s), while serving as a major cause of stress for the persecuted; and

Whereas, Persecution of various forms is underrecognized and is generally inadequately addressed in patient-physician encounters but is one of the most common causes of unexplained illnesses; pain syndromes; and chronic conditions such as tension headaches, pseudo paralysis, psychogenic or nonepileptic seizures, and sundry other unexplainable illnesses known in the past as hypochondriasis and presently as somatization disorder(s); and

Whereas, Women who have been abused have a 50% to 70% increase in central nervous system and stress-related problems; and

Whereas, Children subjected to abuse have a higher incidence of anxiety, depression, and drug abuse and may suffer impairment of brain structure and function; and

Whereas, As physicians we may be the only people in whom the patient may confide regarding such matters; therefore be it

RESOLVED, That the Texas Medical Association urge the Texas Legislature to make laws to protect physicians from personal liability when passing confidential information regarding alleged abuse or persecution of a patient to various governmental agencies; and be it further

RESOLVED, That TMA encourage physicians to make inquiry into patients’ well-being a matter of routine medical practice; and be it further

RESOLVED, That TMA urge physicians to document instances of alleged abuse or persecution in the patient’s medical records.

Related TMA Policy:
1. [55.040 Child Abuse Reporting Laws](#)
2. [325.010 Physicians’ Role in Identifying Violence and Abuse](#)
1 Related AMA Policy:
2 8.10 Preventing, Identifying and Treating Violence and Abuse
Subject: Promoting Safe and Effective Disposal of Polystyrene Foam Medication Case(s) With or Without Ice Packs

Introduced by: Webb-Zapata-Jim Hogg County Medical Society and Lone Star Caucus

Referred to: Reference Committee on Science and Public Health

Whereas, Drug companies ship temperature-sensitive medications to patients and physicians’ offices in polystyrene foam case(s) with ice packs; and

Whereas, In the past, some of the companies supplied return labels to ship the polystyrene foam case(s) back to the company or point of origin after the medications were removed from the case(s); and

Whereas, Now the practice of returning these polystyrene foam case(s) with the ice packs is not encouraged (and instead often discouraged); and

Whereas, Physicians’ offices and patients are disposing polystyrene foam materials and ice packs into the garbage, which eventually ends up in the landfills; and

Whereas, Polystyrene foam takes a long time to degrade, and the ice packs are labeled “safe, nontoxic, not for human consumption”; therefore be it

RESOLVED, That the Texas Medical Association encourage county medical societies to work with local physicians to disseminate information in their office to their patients and staff about the improper disposal of polystyrene foam case(s) with or without ice packs; and be it further

RESOLVED, That TMA encourage pharmaceutical firms to take full responsibility for the return of polystyrene foam case(s) with or without ice packs and paying for the proper and safe disposal or reuse of these materials; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association take a similar resolution to the AMA House of Delegates for consideration.

Related TMA Policy:
95.042 Promoting Safe and Effective Disposal of Unused Medications

Related AMA Policy:
H–135.936 Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 315
2021

Subject:   Possible Upcoming Shortage of Fentanyl and Other Opioid Injections

Introduced by:  Webb-Zapata-Jim Hogg County Medical Society and Lone Star Caucus

Referred to:  Reference Committee on Science and Public Health

 Whereas, Fentanyl injection is used in multiple procedures for conscious sedation; and

 Whereas, Fentanyl injection may be used as an alternative to meperidine injection for conscious sedation
 in patients who cannot tolerate the latter medication; and

 Whereas, If a fentanyl shortage occurs in Texas (e.g., during the COVID-19 pandemic), Texas facilities
 might hoard the medication (as has happened in the past and is happening currently with other medication
 shortages); and

 Whereas, If a shortage occurs, patients who need to undergo procedures will need to use more expensive
 sedation medications or cancel the procedures; and

 Whereas, With limited health care resources and the increasing Texas population subsequently leading to
 more procedures, Texas physicians have to find alternative solutions to ensure procedures performed in
 Texas are affordable to patients; and

 Whereas, The Texas Medical Association supports addiction prevention in the current opioid crisis; and

 Whereas, In 2019, the Drug Enforcement Administration proposed to reduce the amount of fentanyl
 manufactured in the U.S. the following year by 31%; and

 Whereas, The Food and Drug Administration may have underestimated the legitimate medical needs of
 injectable opioid medications used for procedures; therefore be it

 RESOLVED, That the Texas Medical Association restudy the potential shortage of fentanyl and other
 injectable opioids, and promote alternative supplies made domestically; and be it further

 RESOLVED, That TMA work with stakeholders and policymakers to ensure that the legitimate
 availability and affordability of fentanyl and other injectable opioids do not fall below the current and
 future medical need for procedures performed in Texas as well as for disaster preparedness; and be it
 further

 RESOLVED, That TMA advocate physicians using the minimum amount of opioids needed for
 procedures to make patients comfortable; and be it further

 RESOLVED, That the Texas Delegation to the American Medical Association take a similar resolution to
 the AMA House of Delegates for consideration.
Related TMA Policy:

95.033 Drug Shortages and Physician Communications

Related AMA Policy:

H-100.956 National Drug Shortages

Reference:

Subject: Use of Human Tissue for Beneficial Applications (Formally Res 303 2020)

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, A vast amount of valuable human tissue is sent to incineration waste disposal instead of being applied in research and other efforts for the improvement of patient care and scientific investigation; and

Whereas, Current Texas Penal Code, Title 10, Chapter 48, Sec. 48.02, prohibits the purchase and sale of human tissue, even non-organ tissue; and

Whereas, Tissue that currently is being incinerated instead could be used to support the needs of independent laboratories that are innovating methods for enhanced treatment of patients in Texas; and

Whereas, Patients can benefit from the results of studies performed with excess non-whole-organ and nonfetal human tissue; and

Whereas, Many medical organizations in Texas require non-organ human tissue to validate studies and maintain high levels of quality control used in basic and translational medical research; and

Whereas, Some medical organizations in Texas purchase human tissue from other states because Texas does not permit such tissue to be bought within the state, even for research purposes that lead to advancements in patient care; therefore be it

RESOLVED, That the Texas Medical Association study and make active recommendations for a safe harbor in Texas allowing certified entities that have nonfetal tissue and non-whole-organ human tissue waste from a consenting adult patient to use the tissue strictly for research purposes and clinical diagnostics.

Related TMA Policy:
45.008 Blood, Organ, and Tissue Donations
45.011 County Contracts to Recover Tissue in Texas
280.010 Physician Role in Promoting Organ and Tissue Donation and Transplantation
280.012 Human Tissue

Related AMA Policy:
7.3.9 Commercial Use of Human Biological Materials
H-5.994 Use of Fetal Tissue for Legitimate Scientific Research
H-5.985 Fetal Tissue Research

Information:
From the Texas Penal Code, Title 10. Offenses Against Public Health, Safety. and Morals, Chapter 48. Conduct Affecting Public Health:

Sec. 48.02 PROHIBITION OF THE PURCHASE AND SALE OF HUMAN ORGANS.
(a) In this section, “human organ” means the human kidney, liver, heart, lung, pancreas, eye, bone, skin, or any other human organ or tissue, but does not include hair or blood, blood components (including plasma), blood derivatives, or blood reagents. The term does not include human fetal tissue as defined by Section 48.03.

(b) A person commits an offense if he or she knowingly or intentionally offers to buy, offers to sell, acquires, receives, sells, or otherwise transfers any human organ for valuable consideration.

(c) It is an exception to the application of this section that the valuable consideration is: (1) a fee paid to a physician or to other medical personnel for services rendered in the usual course of medical practice or a fee paid for hospital or other clinical services; (2) reimbursement of legal or medical expenses incurred for the benefit of the ultimate receiver of the organ; or (3) reimbursement of expenses of travel, housing, and lost wages incurred by the donor of a human organ in connection with the donation of the organ.

(d) A violation of this section is a Class A misdemeanor.


Amended by: Acts 2017, 85th Leg., R.S., Ch. 441 (S.B. 8), Sec. 16, eff. September 1, 2017.

Sec. 48.03. PROHIBITION ON PURCHASE AND SALE OF HUMAN FETAL TISSUE.

(a) In this section, “human fetal tissue” has the meaning assigned by Section 173.001, Health and Safety Code.

(b) A person commits an offense if the person knowingly offers to buy, offers to sell, acquires, receives, sells, or otherwise transfers any human fetal tissue for economic benefit.

(c) An offense under this section is a state jail felony.

(d) It is a defense to prosecution under this section that the actor:

(1) is an employee of or under contract with an accredited public or private institution of higher education; and

(2) acquires, receives, or transfers human fetal tissue solely for the purpose of fulfilling a donation authorized by Section 173.005, Health and Safety Code.

(e) This section does not apply to:

(1) human fetal tissue acquired, received, or transferred solely for diagnostic or pathological testing;

(2) human fetal tissue acquired, received, or transferred solely for the purposes of a criminal investigation;

(3) human fetal tissue acquired, received, or transferred solely for the purpose of disposing of the tissue in accordance with state law or rules applicable to the disposition of human fetal tissue remains;

(4) human fetal tissue or human tissue acquired during pregnancy or at delivery of a child, provided the tissue is acquired by an accredited public or private institution of higher education for use in research approved by an institutional review board or another appropriate board, committee, or body charged with oversight applicable to the research; or

(5) cell lines derived from human fetal tissue or human tissue existing on September 1, 2017, that are used by an accredited public or private institution of higher education in research approved by an institutional review board or another appropriate board, committee, or body charged with oversight applicable to the research.

(f) With the consent of the appropriate local county or district attorney, the attorney general has concurrent jurisdiction with that consenting local prosecutor to prosecute an offense under this section.

Added by Acts 2017, 85th Leg., R.S., Ch. 441 (S.B. 8), Sec. 17, eff. September 1, 2017.
Whereas, Recurrent flooding in Texas poses serious public health risks as homes are repeatedly inundated with sewage; and

Whereas, Wastewater treatment plants in flood plains and near waterways risk the dissemination of sewage into the homes of Texans; therefore be it

RESOLVED, That the Texas Medical Association support the need for local, county, and state governmental entities to decommission existing and not construct new wastewater treatment plants in or near flood plains and waterways.

Related TMA Policy:
None
Subject: Recurrent Flooding in Texas Must Be Resolved (Formally Res 308 2020)

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Recurrent flooding in Texas poses serious public health risks as homes are repeatedly inundated with sewage; and

Whereas, Various attempts at flood control by local, county, and state governmental entities have failed to prevent recurrent flooding; therefore be it

RESOLVED, That the Texas Medical Association support the need for local, county, and state governmental entities to commit to and be responsible for the necessary resources to effectively eliminate recurrent flooding in Texas.

Related TMA Policy:

None
Subject: Support for the Texas-CARES Program (Formally Res 312 2020)

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Out-of-hospital cardiac arrest (OHCA), including or stemming from sudden cardiac death, drowning, and drug overdose, is a leading cause of death and a major public health problem with enormous impact across Texas; and

Whereas, Large and unacceptable geographic, racial, and socioeconomic disparities in access to basic life-saving care and OHCA survival rates exist; and

Whereas, A coordinated cardiac response system, including prompt bystander action; telecommunicator cardiopulmonary resuscitation (CPR); emergency medical services high-performance CPR; and guideline-based, post-arrest care at hospitals can dramatically improve survival from OHCA; and

Whereas, The 2015 Institute of Medicine report, *Strategies to Improve Cardiac Arrest Survival: A Time to Act*, states that a centralized data registry is fundamental for measuring OHCA incidence and improving OHCA care and survival rates; and

Whereas, The Texas Cardiac Arrest Registry to Enhance Survival (Texas-CARES) Program, an institutional effort to measure OHCA incidence and improve OHCA care and outcomes statewide, was initiated in 2019; therefore be it

RESOLVED, That the Texas Medical Association investigate options, identify strategies, and support ongoing efforts to sustain the Texas Cardiac Arrest Registry to Enhance Survival (Texas-CARES) Program to collect data on out-of-hospital cardiac arrest (OHCA) incidence, 9-1-1 response, emergency medical services (EMS) treatment, and patient outcomes; and be it further

RESOLVED, That TMA work with state, regional, and local EMS organizations, universities, hospitals, public health entities, communities, and the Texas Legislature to support the Texas-CARES registry and quality improvement program to maximize survival after OHCA; and be it further

RESOLVED, That TMA work to ensure the state of Texas shall own the data collected by the Texas-CARES registry; and be it further

RESOLVED, That TMA support adding sudden cardiac arrest as a reportable condition in Texas; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates for consideration.

Related TMA Policy:

100.028 Automated External Defibrillator Availability and Access

280.033 Hypothermia for Adult Out-of-Hospital Resuscitation
Related AMA Policy:

1. H-130.938 Cardiopulmonary Resuscitation (CPR) and Defibrillators
2. H-285.950 Managed Care Organizations’ Use of Physicians to Provide Second Opinions to Physicians
3. Providing Emergency Services
4. D-295.972 Standardized Advanced Cardiac Life Support (ACLS) Training for Medical Students
5. H-300.945 Proficiency of Physicians in Basic and Advanced Cardiac Life Support
6. H-360.998 Cardiac Resuscitation by Nurses
7. D-470.992 Implementation of Automated External Defibrillators in High-School and College Sports
8. Programs
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 320
2021

Subject: Impact of Social Networking Services on the Health of Adolescents

Introduced by: Harris County Medical Society and the Texas Pediatric Society

Referred to: Reference Committee on Science and Public Health

Whereas, Distinct from use of the broader internet, the use of social networking services (SNS) such as Facebook, Twitter, Instagram, Tik Tok, and Snapchat, among others, which are engineered to maximize engagement and have potential for addiction, can result in a dependence with a severity of symptoms and consequences traditionally associated with substance-related addictions; and

Whereas, Adolescents are particularly vulnerable to unhealthy SNS use, the negative effects of which are incompletely understood but involve psychosocial health, neurocognitive development, weight, and sleep; exposure to inaccurate, inappropriate, or unsafe content and contacts; and compromised privacy and confidentiality; and

Whereas, Adolescents under the age of 18 are not recognized in the law as adults, nor do they have the fully developed capacity of adults to understand the risks and long-term implications of online communication, yet they regularly enter into contractual agreements with operators of websites to send and post information about themselves without the knowledge or consent of their parents; and

Whereas, Many of the protections under the Children’s Online Privacy Protection Act of 1998 such as verifiable parental consent may be beneficial if extended to adolescents, yet they currently apply only to children under age 13; therefore be it

RESOLVED, That the Texas Medical Association affirm that use of social networking services has the potential to negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions, and therefore these services should have established, evidence-based, reliable safeguards to protect vulnerable populations from harm; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association introduce a resolution to the AMA House of Delegates to advocate for the study of the biological, psychological, and social effects of social networking services use, and to advocate for legislative or regulatory action, including the expansion of Children’s Online Privacy Protection Act of 1998 protections, to mitigate the potential harm from the use of social networking services to adolescents and other vulnerable populations.

Related TMA Policy:
None

Related AMA Policy:
H-60.915: Emotional and Behavioral Effects of Video Game and Internet Overuse
D-60.974: Emotional and Behavioral Effects of Video Game and Internet Overuse
References:


Whereas, The Texas Department of State Health Services monitors the health of 30 million Texans in 254 counties; and

Whereas, Public health funding has failed to keep pace with Texas’ growth and has been reduced by more than 40 percent (from $26 million in 2013 to $15 million in 2019); and

Whereas, The COVID-19 pandemic has provoked an economic collapse in Texas eclipsing the great recession of 2007-09; therefore be it

RESOLVED, That the Texas Medical Association, which represents 55,000 Texas physicians, work with academic centers, medical schools, and schools of public health to encourage the Texas Legislature to restore and add funding to public health to assist with the current pandemic crisis and prepare for the next.

Related TMA Policy:
- 260.037 Essential Public Health Services
- 260.042 Core Public Health Functions

Related AMA Policy:
- None
Whereas, U.S. Immigration and Customs Enforcement (ICE) operates 30 immigration enforcement 
detention facilities in Texas, with 12 located along the Texas-Mexico border; and
Whereas, As of 2019, Texas detains the highest number of immigrants in the U.S. with more than 14,000 
detained individuals, more than three times Louisiana’s detained population, the second highest at more 
than 4,000 individuals; and
Whereas, Human beings are being held for increasingly longer times in these immigrant detention 
facilities, with the average length of stay increasing from 22 days in 2016 to 34 days in 2017, and recent 
delays in immigration processing from the COVID-19 pandemic are prolonging people’s stay in detention 
facilities; and
Whereas, Detention facilities are unsanitary and overcrowded, lacking basic supplies such as clean water, 
clean clothes, and facilities for bathing and handwashing; and
Whereas, In 2019, the Department of Homeland Security Office of the Inspector General reported that 
ICE has a documented history of refusing to adequately report data on the daily operations of its facilities, 
even though lapses in compliance with detention standards are known to occur, such as failing to meet its 
obligation to employ sufficient medical staff to perform basic exams and treatments for all detainees; and
Whereas, Inadequate access to medical care within immigrant detention facilities has been well 
documented and found to be a contributing factor in 23 out of 52 deaths in ICE detention facilities 
between March 2010 and March 2018; and COVID-19 was the cause of eight out of 21 reported deaths in 
2020; and
Whereas, The American Academy of Pediatrics supports immediate access to medical care when a child 
enters a detention facility, and further, does not believe children should be held in immigration detention 
for any period due to the inability to provide appropriate health care; and
Whereas, Detention facilities lack a centralized authority overseeing the provision of medical care, since 
the ICE Health Service Corps manages the health care of only 22 out of 200 immigration detention 
facilities, leading to inconsistencies in the provision of medical care, with multiple contracts lacking 
specific staffing requirements or 24-hour access to care; and
Whereas, Scope-of-practice violations, including having licensed vocational nurses clinically assess 
patients without physician oversight, and medical neglect, including refusing care to individuals with 
shortness of breath, are documented occurrences inside detention facilities; and
Whereas, Severe medical neglect occurred in 2020 in an ICE detention facility in Georgia where a physician, practicing as a nonboard-certified gynecologist, performed unnecessary hysterectomies on at least 17 women; and

Whereas, Only one-third of ICE detention centers are located within 25 miles of a hospital with intensive care beds, further emphasizing the need for adequate access to care within facilities to prevent worsening conditions; and

Whereas, U.S. Customs and Border Protection (CBP) allowed Texas physicians to provide medical care within immigrant detention facilities in 2014, but starting in 2018 has denied physicians access to those same facilities to provide medical care; and

Whereas, When community physicians were allowed to provide care in CBP detention facilities in 2014, 20 community physicians were on call every day to evaluate children and adults, improving the physician/provider-to-patient ratio in these detention centers; and

Whereas, U.S. District Judge Dolly Gee, supported by 80 physicians and lawyers, ordered the U.S. attorney general to allow physicians access to the CBP detention facilities in the El Paso and Rio Grande Valley regions, in response to findings that children were not receiving medical care because physicians being denied access to these facilities; and

Whereas, Detention centers deny community physicians access to patient medical information from the detention center for released detainees who then seek medical care in the community upon the patient’s release; and

Whereas, On July 24, 2019, Congress passed H.R. 3239, the Humanitarian Standards for Individuals in Customs and Border Protection Custody Act, which outlines sanitation improvements for detention facilities but does not address improvements for medical care provision within detention facilities; and

Whereas, Our Texas Medical Association has previously called for immigrant detention facilities to provide humane, compassionate treatment and basic necessities such as clean water, clean bedding, sufficient food, educational services, and health to those in the centers; and

Whereas, The American Medical Association in AMA Policy D-350.983 resolves to “advocate for access to health care for individuals in immigration detention”; and therefore be it

RESOLVED, That the Texas Medical Association advocate for community physician access to provide medical care in both U.S. Customs and Border Protection and U.S. Immigration and Customs Enforcement immigrant detention facilities; and be it further

RESOLVED, That TMA advocate for the right of community physicians to contact physicians and health care providers working in the immigrant detention facilities, in accordance with HIPAA, to ensure continuity of care for patients transferred to other health care facilities or released from custody.
Relevant TMA Policy:

260.005 Community and Migrant Health Centers

Relevant AMA Policy:

Health Care Payment for Undocumented Persons D-440.985
Improving Medical Care in Immigrant Detention Centers D-350.983
Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992
Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth D-60.968

References:


Texas Medical Association House of Delegates

Resolution 323
2021

Subject: Education and Action to Arrest the Effects of Climate Change on Health
(Tabled Res 309 2021)

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Numerous scientific studies using different rigorous methods for measuring temperature and its many environmental consequences have demonstrated conclusively that the earth’s surface has been rapidly warming since the start of the Industrial Age, and the rate of warming has greatly accelerated since the 1980s. Consequently, the earth’s average temperature has warmed 1°C (1.8°F) since the start of the Industrial Age, while that of the Arctic region has warmed 3°C (5°F), both leading to profound threats to public health; and

Whereas, Numerous scientific studies using different rigorous methods have proved conclusively that the main cause of the earth’s warming is the emission of carbon dioxide (CO₂) and methane (CH₄) –

“greenhouse gases” – from burning fossil fuels including coal, oil, and natural gas; and

Whereas, In January 2020, the Texas Oil and Gas Association acknowledged that fossil fuels contribute to global warming, putting Texans’ health at risk, and that the oil and gas industry must find ways to reduce emissions and make progress in accomplishing it; and Blackrock, the world’s largest investment company, citing an impending fundamental reshaping of the financial markets, announced a significant reallocation of capital out of fossil fuels; and

Whereas, Methane, which commonly leaks from natural gas wells and pipelines, is 86 times more climate warming than CO₂, and although it remains in the atmosphere for only 10-20 years, curtailing its release can buy time in the near term to implement longer-term solutions; and

Whereas, With only 1°C of warming, we are already observing many predicted adverse effects that threaten public health, such as more powerful hurricanes and tornados, coastal flooding from sea level rise, decline of coastal fisheries from increasing ocean temperature and acidification, increases in vector-borne infectious diseases, water supplies threatened by disappearing glaciers, and unprecedented forest fires, which will intensify as climate warming continues; and

Whereas, Massive crop failures from droughts have precipitated regional threats to national security such as the 2011-14 Arab Spring, the Syrian civil war, and the recent onslaught of Central American immigrant caravans, and climate change has long been a major consideration in U.S. defense planning; and

Whereas, Continued climate warming is starting to set off vicious cycles in nature that will result in runaway warming: For example, as ice cover melts, it exposes land or sea that absorbs more solar heat and accelerates ice cover melting; melting of the Arctic permafrost releases methane from putrefaction of long-frozen, mile-thick prehistoric strata of organic matter; and deforestation by fires, pests, and development allows carbon long sequestered in root systems of the trees to escape as methane; and
Whereas, Since added CO2 persists in the atmosphere for centuries, even if we stop adding more, the CO2 already released into the atmosphere will perpetuate the deterioration of our climate, unless we remove it; and.

Whereas, The private sector has developed economy-stimulating technologies capable of replacing fossil fuel burning with nonwarming alternatives such as solar, wind, geothermal, and safe nuclear power generation (e.g., traveling wave technology), as well as reforestation methods and technologies that can remove CO2 from the air and sequester it permanently or turn it into marketable products; and

Whereas, Since scientific projections give only 11 years before progression toward catastrophe becomes irreversible, the U.S. and other major industrial nations must immediately intensify research and development, and scale up clean energy technologies in which Texas is a leader and stands to receive major economic stimulus; and

Whereas, Strong world leadership by the U.S. is required to bring other major CO2-producing countries into similar compliance; therefore be it

RESOLVED, That the Texas Medical Association educate its members, Texas and federal policymakers, and the public on the scientific evidence about the causes and the impact of climate change on the health of Texans, the seriousness of these threats, and nonpartisan evidence-based remedies; and be it further

RESOLVED, That TMA advocate for nonpartisan, evidence-based remedies for climate change and include in its communications on budgetary priorities the future needs of state preparedness for the effects of climate change on human health, such as increased ferocity of natural disasters and more frequent infectious disease outbreaks by vector-borne diseases and dangerous new viruses; and be it further

RESOLVED, That the substance of the education and advocacy be managed through the established mechanisms of the TMA Council on Science and Public Health and the Council on Legislation.

Relevant TMA Policy:
- 260.077 Clean Air in Texas
- 260.098 Reduce Ozone-Causing Emissions From Three Antiquated Coal-Fired Power Plants
- 260.086 Retire Coal-Fired Power Plants and Replace With Cleaner Energy Sources

Relevant AMA Policy:
- Global Climate Change and Human Health H-135.938
- Climate Change Education Across the Medical Education Continuum H-135.919
- Global Climate Change – The “Greenhouse Effect” H-135.977
- AMA Advocacy for Environmental Sustainability and Climate H-135.923
- Stewardship of the Environment H-135.973
Subject: Required Platelet Products at a Facility in Maternal Levels of Care Designation
(Tabled Res 314 2020)

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, The Texas Legislature in 2013 passed a bill, modified slightly in 2015, with the Texas Department of State Health Services as the regulatory authority, mandating that health care facilities providing maternal care in Texas apply for and meet by September 2020 one of four defined standard levels of care to receive Medicaid funding for obstetrical care; and

Whereas, The criteria for such levels of care were defined by a Perinatal Advisory Council consisting of 19 individuals who did not include a transfusion medicine specialist; and

Whereas, The criteria for levels II through IV require that all facilities providing such maternal care keep on site at all times a platelet product for possible transfusion; and

Whereas, Many such facilities had never stocked a platelet on site before and have rarely if ever transfused a platelet product; and

Whereas, The shelf life of a platelet product is only five to seven days total, with a three- to four-day time frame at the hospital in most cases after the logistics of delivery and required testing; and

Whereas, Platelets can be delivered to such facilities if needed for transfusion; and

Whereas, The collection of an apheresis platelet product requires approximately two hours of a volunteer donor’s time and is a valuable resource that should not be wasted; and

Whereas, The community inventory of platelets is already severely strained because of growing demands with increased cancer and transplant care, better trauma survival, and population growth in many areas; thus the requirement for stocking platelets at facilities that will not actually use them puts the entire community supply at risk for those patients who do need them; therefore be it

RESOLVED, That the Texas Medical Association work with appropriate authorities at the Texas Department of State Health Services in reevaluating the requirement for platelets on site at all facilities providing maternal care with a designation of level of care II through IV and remove this onerous requirement.

Related TMA Policy:
None.

Related AMA Policy:
None.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 325
2021

Subject: Employee Rights to Lactation Accommodation (Tabled Res 317 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, In Texas, lactation accommodation rights exclude nonexempt employees of private companies and employees of companies with fewer than 50 employees; and

Whereas, Current Texas policy requires only the following lactation accommodations by public employers: “reasonable amount of break time for an employee to express breast milk” and “a place, other than a multiple user bathroom, shielded from view and free from intrusion;” and

Whereas, Nonpublic employees are covered under the Fair Labor Standards Act, which also only provides lactation accommodation rights to nonexempt employees of companies that employ more than 50 people; and

Whereas, These state and national laws fail to support new mothers classified as exempt employees or small business employees; and

Whereas, State legislation that supports lactation accommodation is associated with higher rates of breastfeeding; and

Whereas, Workplace barriers are a main contributor to low rates of breastfeeding; and

Whereas, Greater legislative support for lactation accommodation is associated with longer exclusive breastfeeding duration; and

Whereas, Texas Medical Association policy acknowledges and “supports breastfeeding and the provision of human milk as critical components of optimal infant and maternal health,” and “recommends [that] every infant be exclusively breastfed or fed exclusively human milk for a minimum of six months”; therefore be it

RESOLVED, That the Texas Medical Association develop model legislation extending employee lactation accommodation rights to employees of private companies and companies with less than 50 employees; and be it further

RESOLVED, That TMA amend Policy 140.008 as follows:

TMA supports the adoption of legislation and employer programs that allow breast feeding mothers to express breast milk safely and privately at work or take time to feed their infants and encourages public facilities to provide designated areas for breastfeeding and breast milk expression.
Related TMA Policy:
TMA Policy 140.008 Breastfeeding and Human Milk

Related AMA Policy:
AMA Support for Breastfeeding H-245.982

References:
2. Right to Express Breast Milk In the Workplace, Chapter 619 H.B. No. 786, 84 Cong. (2015).
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 326
2021

Subject: Pediatric Iron Deficiency Anemia Treatment and Diagnosis Guidelines
(Tabled Res 326 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Texas lacks published guidelines on diagnosing and treating childhood iron deficiency anemia; and

Whereas, The American Academy of Family Physicians and the Centers for Disease Control and Prevention have not published treatment guidelines specifically for children; and

Whereas, The guidelines provided by the American Academy of Pediatrics only specify and cover children from birth to age 35 months; and

Whereas, Texas Health Steps has published guidelines for treatment and prevention of childhood iron deficiency anemia exclusively in children under age 35 months covered by Medicaid; and

Whereas, The Texas Medical Association recognizes the value and potential of evidence-based clinical guidelines to improve consistency, timeliness, and efficacy of clinical care; and

Whereas, Childhood iron deficiency anemia guidelines will empower general pediatricians and primary care physicians to exhaust treatment options within their scope before referring to subspecialty clinics; and

Whereas, A lack of guidelines on diagnosing and treating childhood iron deficiency anemia increases premature referrals to hematology without first attempting treatment with iron supplements; and

Whereas, Needless specialty referrals cause undue financial burdens on patients, particularly rural patients, by requiring them to pay for travel, potentially nonessential testing, and subspecialty physician visits; and

Whereas, The burdens of unnecessary specialty referrals have exacerbated negative effects on physicians and patients amidst the ongoing COVID-19 global health crisis; and

Whereas, Unnecessary referrals congest subspecialty practices and exacerbate the shortage of pediatric hematologists; and

Whereas, The subspecialist shortage creates a bottleneck in the overall health care system, prevents critical patients from receiving timely treatment, and ultimately passes medical costs to taxpayers; therefore be it

RESOLVED, That the Texas Medical Association support collaboration of qualified stakeholders to develop standard practice guidelines for diagnosis and treatment of childhood iron deficiency anemia that
empower primary care physicians to exhaust treatment and care options within their scope before issuing subspecialty referrals.

Related TMA Policy:
180.003 Managed Care Referral Practices
265.018 Evidence-Based Medicine and Practice

Related AMA Policy:
H-410.980 Principles for the Implementation of clinical practice guidelines at the Local/State/Regional Level

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 327
2021

Subject: Expanding Access to Regularly-Scheduled Dialysis for All Individuals With ESRD (Tabled Res 330 2020)

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Science and Public Health

Whereas, Despite near-universal coverage for end stage renal disease (ESRD)-related dialysis under the 1972 Medicare ESRD entitlement program, as of 2017, around 6,500 dialysis-dependent individuals, namely undocumented immigrants, remain uninsured and ineligible for Medicare-covered, regularly scheduled dialysis; and

Whereas, 30% to 50% of these individuals only receive treatment in emergency situations, otherwise known as emergent dialysis; and

Whereas, The 1986 Emergency Medical Treatment and Labor Act mandates emergent dialysis for any individual who presents to the emergency department with indicated symptoms; and

Whereas, Dialysis-dependent undocumented immigrants are on average younger, able-bodied, and employed, but frequent unscheduled dialysis can quickly reduce quality of life; and

Whereas, Undocumented immigrants who receive emergency-only dialysis for five years have a 14 times higher relative hazard of mortality compared with undocumented immigrants receiving regularly scheduled dialysis; and

Whereas, Emergent hemodialysis is a large cost to local health care systems in Texas; for example, emergency dialysis costs $285,000 per patient, annually, in Houston; and

Whereas, A Harris County public hospital showed that restricting regularly scheduled dialysis for undocumented immigrants results, on average, in 152 more days inpatient per year, 25 more emergency department visits per year, and 3.7 times higher cost per patient per year; and

Whereas, A Dallas program that enrolls undocumented ESRD patients in off-exchange private health insurance plans afforded by charitable premium assistance resulted in a 14% mortality risk reduction, reductions in health care utilization, and estimated cost savings of $72,000 per person per year; and

Whereas, currently only two programs – Harris Health System’s Riverside Dialysis Center and San Antonio’s University Health System – provide regularly scheduled dialysis to undocumented immigrants; and

Whereas, 10 states allow undocumented patients with ESRD to receive scheduled dialysis through state, county, or municipal funds, charity, or other sources of nonfederal funds; and

Whereas, States that provide ESRD-related to care to undocumented immigrants have seen no increase in the number of undocumented migrants; and
Whereas, Clinicians providing emergent hemodialysis experience professional burnout due to the moral distress of providing substandard care, and the frustration related to the inappropriate use of resources; and

Whereas, *AMA Journal of Ethics* acknowledges the challenges in access to regularly scheduled dialysis for undocumented immigrants with ESRD and supports continued advocacy for these patients to receive proper care; therefore be it

RESOLVED, That the Texas Medical Association support existing municipal, county, and state programs that allow undocumented immigrants with end-stage renal disease (ESRD) to receive regularly scheduled dialysis; and be it further

RESOLVED, That TMA support universal access to nonemergency, regularly scheduled dialysis as a humane and cost-effective standard of care for all individuals with ESRD, regardless of immigration status, for which dialysis is appropriately indicated; and be it further

RESOLVED, That TMA collaborate with relevant stakeholders in identifying and implementing potential solutions to achieving regularly scheduled dialysis as a standard of care for all individuals with ESRD in Texas.

**Relevant TMA Policy:**
55.057 Health Care of Undocumented Children
110.006 Health Plan

**Relevant AMA Policy:**
H-440.876 Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients

**Sources:**
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 328
2021

Subject: Outreach and Education in Mixed-Status and Undocumented Communities Regarding Information Gathering and COVID-19 Vaccine Distribution

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Roughly 1.6 million undocumented immigrants live in Texas, comprising 6% of the total state population in 2016; and

Whereas, Roughly 2.7 million Texans, including 1.2 million children, live with at least one undocumented family member in the same household; and

Whereas, Immigrants have greater risk of exposure to COVID-19, as they are more likely to work in jobs where they are unable to practice social distancing; and

Whereas, Immigrants have greater risk of exposure to COVID-19, as they are more likely to use public transit to travel between locations; and

Whereas, Immigrants are more likely to live in multigenerational households with elderly family members more susceptible to COVID-19; and

Whereas, Nearly 70% of undocumented immigrant workers have jobs that provide essential infrastructure required for the continued functioning of our nation during the pandemic and our economic recovery following the pandemic; and

Whereas, The Centers for Disease Control and Prevention prioritized COVID-19 vaccinations for essential workers by including food and agricultural workers, manufacturing workers, grocery store workers, public transit workers, and child care workers in Phase 1b; and

Whereas, The American Psychiatric Association recognizes that distrust of the U.S. legal system and fear of deportation are significant barriers limiting undocumented immigrants’ use of health care and social services; and

Whereas, Fear of deportation, mistrust of government agencies, and misinformation have prompted resistance to the COVID-19 vaccine among undocumented immigrant communities; and

Whereas, Large swaths of unvaccinated populations can lead to the resurgence of vaccine-preventable diseases, such as measles, mumps, and rubella, as evidenced in Belgium in 2013; and

Whereas, Despite the exclusion of “testing, screening, or treatment of communicable diseases, including COVID-19” within the public charge rule, fear of being denied a visa may still discourage vaccine uptake among mixed-status and undocumented communities; and
Whereas, The U.S. Department of Health and Human Services (HHS) retrospective report on the 2009 H1N1 influenza pandemic acknowledged that communication and education initiatives should have relied on community-based, faith-based, and grassroots organizations to disseminate information, as minority and disadvantaged populations were not successfully reached; and

Whereas, During the 2009 H1N1 pandemic, the Embassy of Mexico in Washington, D.C., partnered with HHS to develop a one-page flyer in Spanish to address the fears of undocumented immigrants, and distributed it to all Mexican consulates in the U.S.; and

Whereas, Community-based interventions, including outreach activities and inclusion of staff familiar with targeted neighborhoods, have been proven to help overcome distrust among hard-to-reach populations and improve vaccine delivery to them; and

Whereas, A tailored intervention that detects and addresses hesitancy is an evidence-informed strategy to address vaccine hesitancy in subgroup populations, such as undocumented immigrants; therefore be it

RESOLVED, That our Texas Medical Association amend policy 260.080 Vaccine Delivery as follows:

Vaccine Delivery: The Texas Medical Association is dedicated to helping ensure all Texans are fully vaccinated. TMA recommends several actions to help remove barriers for physicians and add accountability and transparency to all aspects of vaccine delivery.

1. That TMA work with the Texas Legislature to highlight the critical contribution of Texas physicians in reaching the state’s public health immunization goals by eliminating vaccine-preventable illnesses and also ensuring comprehensive services in the medical home setting. In addition, TMA supports legislation to:

   a. Eliminate the business tax on vaccines;
   b. Establish a purchase reference for acquisition of each vaccine recommended for children, based on a standard transparent source, such as the Centers for Disease Control and Prevention (CDC) Private Sector Price List;
   c. Mandate vaccine payment reporting by insurance companies to determine if they are covering the true costs of these preventive services;
   d. Further universal reporting to the state’s immunization registry;
   e. Protect and preserve as the primary site of the receipt of immunizations a patient-centered medical home with a primary care physician; and
   f. Mandate electronic reporting, by the vaccinating provider, of vaccines administered to children and adults outside their medical home (e.g., in pharmacies or through community-based delivery) to either (i) the public health agency immunization registry, or (ii) the local public health immunization exchange using the appropriate, current national health information standard (e.g., HL7 2.5.1 or C-CDA release 2.1 Common Clinical Data Set).

2. That TMA support increased federal funding of the Section 317 program and state funding to increase physician payments for the administration of immunizations to patients in the Medicaid and Texas Vaccines for Children programs; encourage the Texas Department of State Health Services and CDC to work toward a significant decrease in the administrative burden for physicians participating in the federal Vaccines for Children program so more physicians can provide vaccines under the program at reasonable cost; and support federal and continued state funding to preserve the Adult Safety Net Program for access to vaccines, noting the health care savings and health benefits of this program greatly exceed the immediate cost.
3. That TMA oppose any policies, regulations, or legislation requiring physicians and institutions to collect data regarding a patient's legal residence status and proof of citizenship as a condition of providing vaccines.

4. That TMA work with the Texas Department of State Health Services and other recognized groups to expand and promote resources to assist physician members on how practices can best establish a business and public health case for providing immunizations and determine the tools necessary to negotiate best price (CPH Rep. 1-A-09; amended CSPH Rep. 5-A-19)

; and be it further

RESOLVED, That our TMA create and implement accessible outreach and education programs pertaining to the COVID-19 vaccine that can be distributed via community-based, faith-based, and grassroots organizations in mixed-status and undocumented communities; and be it further

RESOLVED, That our TMA collaborate with community-based, faith-based, and grassroots organizations to create outreach and education programs for undocumented and mixed-status immigrant communities.

Related TMA Policy:
135.010 Immunization Education Efforts for Texas
55.057 Health Care of Undocumented Children

Related AMA Policy:
Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
Patient and Physician Rights Regarding Immigration Status H-315.966
Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921
Education and Public Awareness on Vaccine Safety and Efficacy H-440.830

References:


Subject: In Support of Comprehensive Sexuality Education Reform

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, In 1995, 81% of adolescent males and 87% of adolescent females reported receiving formal instruction about birth control methods compared with the 55% of adolescent males and 60% of adolescent females in 2011-13; and

Whereas, As of 2019, Texas ranked among the top 10 states in teen birth rate with a teen birth rate of 24%; and

Whereas, Texas is not among the 30 states that require public schools to teach sex education; and

Whereas, According to the Sexuality Information and Education Council of the United States (SIECUS), Texas does not require sex education to be medically accurate with some programs often providing medically inaccurate information about abortion and using textbooks that omit the use of condoms as a method to prevent sexually transmitted infections (STIs); and

Whereas, 25% of school districts in Texas did not teach sex education; and

Whereas, As of 2015-16 only 17% of school districts in Texas taught abstinence-plus sex education that included instruction on contraceptive use and birth control options; and

Whereas, A recent systematic review by the American Academy of Pediatrics demonstrated there is no evidence that abstinence-only programs delay initiation of sexual intercourse; and

Whereas, In 2018, SIECUS reported that 89% of voters believe it is important to teach sexuality education to middle schoolers, and 98% of voters believe it is important to teach sexuality education to high schoolers; and

Whereas, Comprehensive sexuality education is defined as sexuality education composed of human sexuality, intimate relationships, human sexual anatomy, sexual reproduction, sexually transmitted infections, sexual activity, consent, sexual orientation, abstinence, contraception, and reproductive rights and responsibilities; and

Whereas, Comprehensive sexuality education can reduce pregnancy, HIV, and STIs for U.S. children and adolescents; and

Whereas, An examination of the National Survey of Family Growth for teens aged 15-19 revealed that teens who received comprehensive sexuality education were 50% less likely to report a pregnancy than those who received abstinence-only education; and
Whereas, A methodological review of comprehensive sex education aimed at reducing high-risk sexual activity was 57% effective in reducing high-risk sexual behaviors; and

Whereas, Research on comprehensive sex education programs shows these programs help teens delay the onset of sexual activity, reduce the number of sexual partners, and increase condom and contraceptive use; and

Whereas, The American College of Obstetricians and Gynecologists, Society for Adolescent Health and Medicine, American Medical Association, American Public Health Association, National Education Association, and National School Boards Association endorse comprehensive sexuality education for teens that includes abstinence, contraceptive use, human sexuality, and STIs, and they oppose abstinence-only education; and

Whereas, AMA Policy H-170.968 encourages an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; and

Whereas, If a school district uses the curriculum developed by the Texas Department of State Health Services, it must teach that homosexuality is an unacceptable lifestyle that, according to Texas Penal Code Section 21.06, can be criminally penalized; and

Whereas, Inclusive sex education programs are those that help youth better understand gender identity and sexual orientation with medically accurate and age-appropriate information; and

Whereas, Sex education programs must be inclusive of LGBTQ+ members for LGBTQ+ youth to have health benefits comparable to their non-LGBTQ+ peers, such as a better understanding of their gender identity, sexual orientation, and need for contraception that in turn supports positive health outcomes, such as teen pregnancy and STI rates comparable to the rates of their non-LGBTQ+ peers; and

Whereas, AMA Policy H-170.968 supports and comprehensively addresses the sexual behavior of all people, inclusive of sexual and gender minorities; and

Whereas, Fewer than 5% of LGBTQ youth had health classes that provided accurate representation of related topics; and

Whereas, Literature from Guttmacher Institute and Columbia University finds that the impact of COVID-19 on adolescents and young adults will have an immediate and long-term negative effect on their sexual and reproductive health needs and behaviors due to their schools not prioritizing sexuality education; therefore be it

RESOLVED, That our Texas Medical Association amend Policy 55.016 Sexuality Education as follows:

**55.016 Sexuality Education**

Sexuality Education: The Texas Medical Association supports age- and developmentally appropriate, comprehensive sexuality education from kindergarten through college that (a) uses an effective, evidence-based, medically accurate comprehensive curriculum; (b) should address abstinence-plus practices, avoidance of sexual risk-taking behaviors, various forms of contraception, availability of reproductive health choices, and include responsible decisionmaking, social influences, and peer pressures; and (c) includes factual information and
skill-building related to sexual reproduction anatomy, biology, and other health-related knowledge that would aid in preventing pregnancy and transmission of sexually transmitted diseases.


Relevant TMA Policy:
55.016 Sexuality Education

Relevant AMA Policy:
Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968
Human Sexuality Education H-170.966

References:
Subject: In Support of Reevaluating the Use of Race in Estimated Glomerular Filtration Rate

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

1 Whereas, “Race” has been poorly defined in medical practice, ranging from use as a population descriptor to a proxy for ancestral background; and

2 Whereas, Racial categories in the U.S. Census have changed every decade since the 1790s; and

3 Whereas, Use of race as a surrogate for shared genetic and biological variation is limited by actual genomic variability within racial categories; and

4 Whereas, Clinical corrections for race were developed on the basis of race being a proxy for biological traits; and

5 Whereas, The American Medical Association and the American Academy of Family Physicians recognize that race is a social rather than a biological construct; and

6 Whereas, The premise of the race correction in estimated glomerular filtration rate (eGFR) is based on the assumption that Black individuals have more muscle mass and thus release more creatinine into their blood at baseline; and

7 Whereas, The two most widely used equations to estimate GFR, the Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) equation and the Modification of Diet in Renal Disease study equation, yield a higher estimated GFR for Blacks than whites at all levels of creatinine; and

8 Whereas, AMA Policy H-65.953 and the American Academy of Family Physicians support ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice; and

9 Whereas, The National Kidney Institute and the American Society of Nephrology created a task force in September 2020 to reevaluate eGFR as a metric based on the premise that race is a social rather than a biological construct; and

10 Whereas, A variety of major medical centers, including Beth Israel Deaconess Medical Center, Stanford, and the University of Washington, have successfully discontinued the race correction in their eGFR calculation; and

11 Whereas, A New England Journal of Medicine analysis of 13 clinical corrections for race found that they each systemically directed care away from Black or Latinx patients in areas of existing health disparities; and
Whereas, AMA Policy H-350.974 recognizes that racial and ethnic disparities are a major public health problem in the U.S. and a barrier to effective medical diagnosis and treatment, and states that the elimination of racial and ethnic disparities is of highest priority; and

Whereas, Despite similar rates of chronic kidney disease (CKD) across different major racial and socioeconomic groups, the rate of end-stage renal disease in Black patients is approximately 3.5 times the rate of white patients, and a contributing factor is that Black patients with CKD are more likely than whites to have delayed or no nephrology referral; and

Whereas, If the consideration of race were removed from the CKD-EPI equation, the recommended formula for estimating GFR in adults, one out of four Black patients with CKD would be classified as having a more severe state of CKD and would be eligible for more advanced care; and

Whereas, If race were removed from the CKD-EPI equation, more than 60,000 Black adults in the U.S. with CKD would be able to receive specialty care for kidney disease, and the number of Black adults eligible for kidney transplant would increase by 3%; therefore be it

RESOLVED, That our Texas Medical Association recognize that race is an inaccurate proxy metric to use in estimating glomerular filtration rate (GFR) because race is a social rather than biological construct; and be it further

RESOLVED, That our TMA support and encourage efforts to study and redefine the currently used race correction factor, so that GFR can be estimated with factors other than self-identified race.

Related TMA Policy:
265.018 Evidence-Based Medicine and Practice
265.030 Social Determinants of Health

Related AMA Policy:
Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953
8.5 Disparities in Health Care
Racial and Ethnic Disparities in Health Care H-350.974
Race and Ethnicity as Variables in Medical Research H-460.924
Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities H-440.869
Strategies for Eliminating Minority Health Care Disparities D-350.996

References:
4. Begley S. Racial bias skews algorithms widely used to guide patient care. STAT. Published 2021.


Subject: Support for Increasing Digital Access

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The United Nations has declared universal internet access a basic human right; and
Whereas, Access to the internet, particularly in the era of COVID-19, influences all six social determinants of health domains as defined by the American Medical Association, including access to health care, education, and social support; and
Whereas, More than 2 million Texas households do not have high-speed internet; and
Whereas, Only 69% of rural households have access to high-speed internet, but the U.S. Census Bureau reports that three times as many households in urban areas remain unconnected compared to rural areas; and
Whereas, Roughly half (49%) of U.S. senior citizens reported they did not have home broadband services in 2017; and
Whereas, Half of non-broadband users state they do not subscribe to broadband because the cost is too expensive; and
Whereas, 52 million adults do not know how to use a computer properly even when they have access to one; and
Whereas, The proportion of respondents to the National Telecommunications and Information Administration (NTIA) survey who reported that they did not subscribe to home broadband primarily due to digital literacy issues doubled between 2009 and 2017; and
Whereas, Adults who are not digitally literate are, on average, less educated, older, and more likely to be Black, Hispanic, or foreign born, compared to digitally literate adults, populations which tend to be concentrated in urban centers; and
Whereas, Timely, accurate information pertaining to the COVID-19 pandemic, including stay-at-home orders or vaccine distribution information, is often distributed over the internet; and
Whereas, The ability to self-isolate during the COVID-19 pandemic is tied to individuals’ access to home high-speed internet; and
Whereas, Many hospital systems have switched to using telehealth to deliver care during the COVID-19 pandemic; and
Whereas, Telehealth visits increased by 154% from March 2019 to March 2020 in the United States, illustrating the large increase in the use of telehealth; and

Whereas, Digital literacy gaps have been shown to decrease the efficacy of telehealth interventions; and

Whereas, Existing AMA policy H-65.960 (Health, In All Its Dimensions, Is a Basic Right) acknowledges that optimizing the social determinants of health is an ethical obligation; and

Whereas, Existing AMA policy H-478.980 (Increasing Access to Broadband Internet to Reduce Health Disparities) advocates for the expansion of broadband and wireless connectivity to rural and underserved areas of the U.S.; and

Whereas, Existing TMA policy does not address the digital divide in urban areas or digital literacy barriers to internet access; and

Whereas, Existing TMA policy (275.006 Broadband Internet Access to Rural Texas) advocates for expeditious expansion of broadband connectivity to all rural areas of Texas; therefore be it

RESOLVED, That the Texas Medical Association advocate for increased access to high-speed home broadband internet, particularly to address needs in both elderly and underprivileged communities for the purposes of improving telehealth access and reducing health disparities; and be it further

RESOLVED, That TMA advocate to improve digital literacy, particularly to address needs in both elderly and underprivileged communities for the purposes of improving telehealth access and reducing health disparities.

Related TMA Policy:
275.006 Broadband Internet Access to Rural Texas
290.002 Telemedicine Use to Improve Health Care

Related AMA Policy:
Health, In All Its Dimensions, Is a Basic Right H-65.960
COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963

References:


Whereas, Transgender youth have a greater risk of developing internalizing psychopathologies, suicidality, and substance use disorders compared with cisgender youth due to gender dysphoria, discrimination, and stigma; and

Whereas, Transgender and gender-nonconforming youth report decreased use of health care resources compared with cisgender youth because of barriers to health care access such as anticipated stigma, unmet gender affirmation needs, delayed access to pubertal blockers or hormone replacement therapy, and insurance exclusions; and

Whereas, Transgender youth of color face unique barriers that limit access to medical care such as high rates of homelessness, arrests, and detentions, and exposure to street violence; and

Whereas, Gender-affirming care refers to care that distinguishes between gender identity and sex, validates patients’ gender identity, avoids pathologizing transgender identities, and provides a safe environment for transgender patients; and

Whereas, Transgender youth who receive gender-affirming medical care experience longitudinally improved mental health status, including decreased suicidal ideation, depression, and gender dysphoria; and

Whereas, Access to gender-affirming care has been further restricted during the COVID-19 pandemic, delaying medically necessary and time-sensitive treatments, which can exacerbate adverse mental health outcomes among transgender youth; and

Whereas, Texas Medical Association Policy 55.058 supports evidence-based, gender-affirming therapies for adolescents but does not address or articulate a strategy against efforts to criminalize those who provide evidence-based therapy; and

Whereas, State legislators in Texas, Alabama, Colorado, Florida, Illinois, Kentucky, Missouri, Oklahoma, South Carolina, and South Dakota have introduced legislation that restricts transgender youths’ access to gender-affirming care and restricts physicians from providing gender-affirming care; and

Whereas, In May 2019, six leading medical organizations – the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, and American Psychiatric Association – issued a joint statement opposing “efforts in state legislatures across the United States that inappropriately interfere with the patient-physician relationship, unnecessarily regulate the evidence-based practice of medicine and, in some cases, even criminalize physicians who deliver safe, legal, and necessary medical care”; therefore be it
RESOLVED, That our Texas Medical Association opposes efforts to criminalize evidence-based, gender-affirming care for transgender youth; and be it further

RESOLVED, That our TMA amend Policy 55.058 Sexual Orientation Change Efforts for Minors as follows:

(1) The Texas Medical Association supports treatment and therapies rooted in acceptance and support regarding an individual’s sexual orientation and gender identification and therefore opposes practices aimed at changing an individual’s sexual orientation, including conversion therapy; (2) TMA supports physician efforts to provide medically appropriate therapies affirming gender identity and opposes the criminalization of these practices; (23) TMA supports the prohibition of any person licensed to provide mental health counseling from engaging in sexual orientation change efforts with patients younger than 18 years of age. TMA supports the practice of evidence-based therapies and will aggressively oppose the use of potentially harmful, unproven therapies for children. In addition, the association supports any regulatory changes to prohibit coverage for conversion therapy under the state’s Medicaid program as well as any health insurers in the state; (34) TMA encourages physicians to stay informed on the potential harms associated with sexual orientation change efforts. (CM-CAH & TF Rep. 4-A-17)

Related TMA Policy:
55.004 Adolescent Sexual Activity
55.058 Sexual Orientation Change Efforts in Minors
265.028 Improving LGBTQ Health Care Access
55.016 Sexuality Education
60.008 Rejection of Discrimination
60.009 Gender Identity and Public Facility Use
60.010 Opposing Legislation that Mandates Physician Discrimination

Related AMA Policy:
Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
Plan for Continued Progress Toward Health Equity H-180.944
Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927
Preventing Anti-Transgender Violence H-65.957
Access to Basic Human Services for Transgender Individuals H-65.964
Support of Human Rights and Freedom H-65.965
Removing Financial Barriers to Care for Transgender Patients H-185.950
Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927
Improving Screening and Treatment Guidelines for Intimate Partner Violence (IPV) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (LGBTQ) D-515.980
Patient-Reported Outcomes in Gender Confirmation Surgery H-460.893
Health Disparities Among Gay, Lesbian, Bisexual, Transgender and Queer Families D-65.995
Patient Access to Treatments Prescribed by Their Physicians H-120.988

References:


Subject: Opposition to Sobriety Requirement for Hepatitis C Treatment

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The annual incidence rate of hepatitis C virus (HCV) in the U.S. has tripled in the past decade, and conservative estimates place prevalence at 2.4 million people in the U.S. and 376,000 people in Texas; and

Whereas, Additionally, with current HCV management protocols, a projected 320,000 patients will die, 157,000 will develop hepatocellular carcinoma, and 203,000 will develop decompensated cirrhosis during the next 35 years; and

Whereas, Much of the morbidity and mortality associated with HCV can be prevented with early diagnosis and treatment, as direct acting antiviral (DAA) medications cure more than 95% of those with HCV; and

Whereas, Injection drug use is the largest driving factor for HCV spread, and an estimated 53% of people who inject drugs (PWID) have HCV, relative to 1% of the general U.S. population; and

Whereas, In spite of their greater vulnerability to HCV, PWIDs face greater barriers to accessing treatment, as some Medicaid groups require abstinence from alcohol and substance use for up to six months prior to receiving DAA medications; and

Whereas, One study found that up to 96% of PWID who were diagnosed with HCV would likely be restricted from accessing essential treatment based on unwarranted contraindications, such as drinking, depression, and recent drug injection, compared with only 11% of the non-PWID diagnosed with HCV; and

Whereas, Those with substance use disorder have the same HCV cure rates as their healthy counterparts, and were shown to have high adherence to treatment and low six-month reinfection rates; and

Whereas, The Social Security Act states that requirements by the states for abstinence “should not result in the denial of access to effective, clinically appropriate, and medically necessary treatments using DAA drugs for beneficiaries with chronic HCV infections”; and

Whereas, In Texas, Medicaid fee-for-service requires 90 days of sobriety before even a prior authorization request to receive curative treatment for hepatitis C; and

Whereas, Thirteen of the 15 Medicaid managed care organizations in Texas (Aetna, Amerigroup, Blue Cross and Blue Shield of Texas, Cigna HealthSpring, Christus Health Plan, Community Health First Plans, El Paso First Health, FirstCare STAR Health Plans, Molina Healthcare, Scott & White, Sendero Health Plans, Superior HealthPlan, and UnitedHealthcare) have a 90-day requirement of sobriety to be eligible to receive treatment; and
Whereas, The National Viral Hepatitis Roundtable and the Center for Health Law and Policy Innovation at Harvard Law School report that state laws requiring abstinence greatly limit those who can receive hepatitis C treatment, and they graded Texas “D+”; and

Whereas, The Centers for Medicare & Medicaid Services, U.S. Department of Veteran Affairs, and leading professional associations of Medicaid providers have stated that sobriety restrictions are an unnecessary restriction to care; and

Whereas, Abstinence policies prior to treatment are in contradiction to the Recommendations for Testing, Managing, and Treating Hepatitis C published jointly by the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America; and

Whereas, Not providing hepatitis C treatment to those with substance use disorder is discriminatory towards patients with a substance abuse disorder and may violate the Americans with Disabilities Act, and the Center for Health Law and Policy Innovation at Harvard Law School has asked the Department of Justice to investigate this matter; and

Whereas, In 2020, 74% of Medicaid programs had stopped enforcing abstinence requirements prior to providing hepatitis C treatment, and Texas is one of the last 13 states that still imposes a sobriety requirement; and

Whereas, By increasing DAA treatment in injection drug users, other countries halved HCV prevalence (51% in 2015 to now 18% as of 2019), which has decreased transmission to younger injection drug users; and

Whereas, Those with HCV are at an increased risk of serious illness from COVID-19, and withholding life-saving treatment for HCV during the COVID-19 pandemic due to sobriety requirements could increase morbidity and mortality; therefore be it

RESOLVED, That our Texas Medical Association oppose the Texas Medicaid 90-day sobriety requirement for hepatitis C virus (HCV) treatment; and be it further

RESOLVED, That TMA support efforts to remove the sobriety requirement as a barrier to HCV treatment; and be it further

RESOLVED, That TMA encourage the awareness and avoidance of barriers relating to access to HCV treatment.

Related TMA Policy:

260.060 Hepatitis C
95.045 Evidence-Based Management of Substance Use Disorders
95.021 National Drug Policy
145.019 Mental Health Equitable Treatment and Parity

Related AMA Policy:

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845
Substance Use and Substance Use Disorders H-95.922
Federal Drug Policy in the United States H-95.981
References:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 334
2021

Subject: Racism as a Public Health Issue

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Institutional racism is defined as policies, rules, practices, and the like that have become a usual part of the way an organization or society works and that result in and support a continued unfair advantage to some people and unfair or harmful treatment of others based on race; and

Whereas, After controlling for socioeconomic differences, race and ethnicity remain predictors of the quality of health care patients receive; and

Whereas, In a 2018 National Health Interview Survey, 13.8% of Black respondents and 12.3% of Hispanic or Latino respondents reported health in fair or poor condition compared with only 8.3% of white respondents; and

Whereas, Individuals from racial minority groups consistently experience worse health outcomes and lower quality of care; and

Whereas, The American College of Physicians has found that Black/African American people are at risk of being subjected to discrimination and violence against them because of their race, endangering them and even costing them their lives; and

Whereas, A study suggests that medical students and residents hold and may use false beliefs about biological differences between Black and white patients to inform medical judgments; and

Whereas, Hospitals and clinics that previously were designated for racial and ethnic minorities continue to experience significant financial constraints, are often underresourced, and are improperly staffed; and

Whereas, Framing racism as a public health issue can compel organizations and governmental units to begin initiatives to address racism; and

Whereas, Many Texas medical schools and health science centers have initiated antiracism resources for their students; and

Whereas, A hospital faculty development workshop designed to teach about the role of racism in creating disparities in health care reported a significant change in attitude in 72 out of 120 participants with regard to racism and related issues; and

Whereas, The Association of American Colleges has stated that the medical community has used diversity, equity, and inclusion programs to help reduce racial bias and discrimination; and

Whereas, The American Hospital Association acknowledges racism and has provided resources on addressing and mitigating the effects of racism during the COVID-19 pandemic; and
Whereas, The cities of Austin and San Antonio, and Harris and Dallas counties have acknowledged racism as a public health issue; and

Whereas, The American Pharmacists Association and the American Academy of Family Physicians recognize the impact of racism within the U.S. health care delivery system, which has historically engaged in the systematic segregation and discrimination of patients based on race and ethnicity, the effects of which persist to this day; and

Whereas, American Medical Association Policy H-350.974 acknowledges that racial health disparities pose a major public health problem; and

Whereas, AMA Policy 350.025MSS recognizes that systemic, cultural, interpersonal, and other forms of racism are a threat to public health and continue to cause harm; and

Whereas, Texas Medical Association Policy 50.012 recognizes that racial health disparities in cancer care lead to worse health outcomes in racial minorities and are a public health issue; and therefore it be

RESOLVED, That our Texas Medical Association acknowledge that systemic and structural racism within the health care system has caused and continues to cause health inequity that harms marginalized communities; and be it further

RESOLVED, That TMA recognize racism, in its systemic, cultural, interpersonal, and other forms, poses a threat to public health, the advancement of health equity, and the delivery of appropriate medical care; and be it further

RESOLVED, That TMA support resource development for health care institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, physicians, providers, and populations.

Related TMA Policy:
50.012 Addressing Cancer Health Disparities
60.008 Rejection of Discrimination

Related AMA Policy:
Racial and Ethnic Disparities in Health Care H-350.974

References:
Whereas, The Texas Department of Criminal Justice has one of the highest rates of COVID-19 infections and deaths of any state or federal prison system in the country; and

Whereas, COVID-19 deaths in the Texas prison system have remained high throughout the course of the pandemic, while other states with prison systems that had high death counts early in the pandemic adopted measures that reduced deaths over time; and

Whereas, Prisons and jails are breeding grounds for virus transmission among the incarcerated population and the general public due to dense crowding, disparate access to hygiene supplies and personal protective equipment, inability to quarantine and maintain social distance, transfers between facilities and release, and jail staff who often become vectors of disease transmission; and

Whereas, COVID-19 infection in prisons and jails gives rise to more severe illness and mortality because of the high rates of chronic disease among incarcerated populations; and

Whereas, The United Nations Office on Drugs and Crime recognizes that alternatives to imprisonment, reassessing pretrial detention, and commuting sentences all are measures that should be considered to protect people inside and outside the prison; and

Whereas, The U.S. Supreme Court applied the Eighth Amendment to incarcerated people such that they are entitled to a quality of medical care equivalent to that provided for the general public and that a lack thereof constitutes cruel and unusual punishment; and

Whereas, The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) dictate that health care in prison should include preventive medicine, which in the context of COVID-19 includes access to educational information, hygiene supplies, testing, and personal protective equipment; and

Whereas, Texas Department of Criminal Justice leadership have undermined measures for mitigating viral spread during the pandemic: Prison employees have been forced to share and reuse personal protective equipment, infected prisoners are often not isolated or quarantined for an adequate length of time, and prisoners have been transferred to new facilities while sick; and

Whereas, Incarcerated individuals are disincentivized from seeking medical care during the pandemic for fear of being placed in solitary confinement or otherwise punished; and

Whereas, Access to health care for other reasons, such as substance abuse treatment, has also diminished due to the pandemic and resultant strains on prison personnel; many prisons have restricted access for nonessential staff, including contracted and external physicians and health care providers; and
Whereas, The COVID-19 vaccine rollout plan for Texas includes no timeline or strategy for the vaccination of incarcerated and detained individuals, reflecting a violation of the state’s duty to protect the health of those in its custody; and

Whereas, The Centers for Disease Control and Prevention (CDC) has not approved using incarcerated people as a strategy to mitigate local community COVID-19 transmission or relieve an overwhelmed medical system; and

Whereas, CDC defines incarcerated people as a population protected from research, given their vulnerability to undue influence compared with the general population; and

Whereas, Although incarcerated people enjoy the right to work, they are not in the ethical position to provide informed consent to work in hazardous conditions; and

Whereas, The American Medical Association has two policies supporting health care for the incarcerated, H-430.986 and D-430.997, and TMA currently has none; therefore be it

RESOLVED, That our Texas Medical Association recognize incarcerated health is public health by protecting the health and safety of incarcerated and detained individuals through the following actions including, but not limited to:

1. Advocating for equivalence of care for those incarcerated and detained;
2. During infectious disease outbreaks, (a) advocating for the urgent provisioning of personal protective equipment and needed hygiene supplies, and (b) encouraging the adoption of safety measures such as social distancing, reduced crowding, and decarceration to mitigate disease spread in facilities;
3. Promoting access to nonemergency health services during disease outbreaks;
4. Opposing using incarcerated people to respond to public health emergencies;
5. Recognizing incarcerated and detained individuals as a high-risk group for prioritization of vaccine access;
6. Encouraging the enactment of safeguards that protect the ability of incarcerated people to access care without fear of retaliation;
7. Supporting strengthening the Eighth Amendment rights of incarcerated people to access adequate medical care;
8. Supporting legislation requiring U.S. Occupational Safety and Health Administration protections in incarcerated workplaces;
9. Encouraging the Texas state Medicaid agency to accept and process Medicaid applications from eligible juveniles and adults who are incarcerated to improve access to care, particularly during a pandemic;
10. Advocate for adequate payment to physicians and health care providers, including primary care, mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to reentry into the community;
11. Supporting partnerships and information-sharing among correctional systems, community health systems, and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system; and
12. Supporting (a) linkage of those incarcerated to community clinics upon release to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community physicians and health care providers for those transitioning from a correctional institution to the community.
Related TMA Policy:
1. 260.042 Core Public Health Functions
2. 260.103 Disaster Preparedness Planning and Response
3. 260.037 Essential Public Health Services
4. 105.009 Informed Consent

Related AMA Policy:
7. 7.1.2 Informed Consent in Research
8. Health Care While Incarcerated H-430.986
9. Support for Health Care Services to Incarcerated Persons D-430.997

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 336
2021

Subject: Results and Regulation of Freestanding Birthing Centers and at Home Birthing Services
(Formally Res 426 2020)

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Texas’ maternal mortality rates are higher than the U.S. average; and
Whereas, Many mothers are opting to deliver their babies at birthing centers and at home; and
Whereas, Adequate regulation of individuals assisting with these deliveries appears not to exist; and
Whereas, Clarity is needed to determine if the delivery of a baby is the practice of medicine; and
Whereas, Studies show worse outcomes for mother and child when complications arise during deliveries at home or in freestanding birthing centers; and
Whereas, Texas Medical Association has policy about reducing maternal mortality; therefore be it
RESOLVED, That the Texas Medical Association work with state agencies to study the results, regulation, and quality review mechanisms of freestanding birthing centers and at-home birthing services; and be it further
RESOLVED, That TMA determine if additional regulations and public education are needed.

Related TMA Policy:

30.005 Midwifery
330.011 Home Deliveries
330.012 Obstetrical Delivery in the Home or Outpatient Facility
330.013 Maternal Mortality Review
330.015 Physician-Led Initiatives to Address Maternal Mortality and Morbidity
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 337
2021

Subject: Advocating for Evidence-Based Care for Incarcerated Pregnant Women in Texas Correctional Facilities

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Approximately 4,000 pregnant women pass through Texas county jails each year, and Texas state prisons admit an average of 241 pregnant inmates every year; and

Whereas, In 1976 in Estelle v. Gamble, the U.S. Supreme Court established that correctional facilities have an obligation to provide access to health care in prison settings under an interpretation of the Eighth Amendment; and

Whereas, A significant number of pregnant inmates will require at least one prenatal visit during their period of incarceration based on the average length of stay for pregnant inmates and the current American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) Guidelines for Perinatal Care; and

Whereas, Section 501.0666 of Texas Government Code regarding inmate welfare states that pregnant inmates shall be provided sufficient food and dietary supplements, including prenatal vitamins, as ordered by an appropriate medical professional; and

Whereas, According to the Texas minimum jail standards in Texas Administration Code (TAC) Section 273.2, each correctional facility must follow a written plan approved by the Texas Commission on Jail Standards, that “provide[s] procedures for obstetrical and gynecological care, mental, nutritional requirements, special housing and appropriate work assignment, and the documented use of restraints during labor, delivery, and recovery for pregnant inmates”; and

Whereas, According to TAC Section 273.2(15), each facility under its written plan also must train staff to identify when a pregnant inmate is in labor and provide access to appropriate care; and

Whereas, According to the Texas Commission on Jail Standards 2016 House Bill 1140 report on the care of pregnant women in Texas county jails, approximately 27% of sheriffs representing each county jail report having no specific policy regarding frequency of prenatal visits with a specified type of physician or provider; and

Whereas, Regarding initial and routine visits to the physician or provider, sheriffs report conducting or monitoring blood testing (16%), blood pressure on initial visit (14%), fetal heart tones (18%), urinalysis (18%), abdominal palpations (18%), fetal movement (16%), weight measurement (17%), and symphysis fundus height (15%); and

Whereas, Also regarding prenatal procedures and tests, 17% of sheriffs report having no jail policy regarding the frequency of blood testing, and 18% report having no specific jail policy on the frequency...
of monitoring blood pressure, fetal heart tones, urinalysis, abdominal palpations, fetal movement, weight, or symphysis fundus height; and

Whereas, In regard to substance abuse management, sheriffs report having routinely available chemical dependency treatment (24%), detox protocol (45%), detox support (36%), and methadone access (11%); and

Whereas, Regarding nutritional standards, 150 county jails report an average daily caloric intake of 2,780, ranging from 1,800 to 6,800 calories, with some counties reporting caloric need is determined by trimester or by a physician on an individualized basis, demonstrating a lack of uniformity across facilities; and

Whereas, Regarding supplemental nutrition, sheriffs report they routinely provide a supplemental snack (70%), prenatal vitamins and fresh fruits/vegetables (81%), nutritional beverages such as Ensure (29%), and fresh water (89%); and

Whereas, Texas does not require jails to follow specific guidelines on the provision of appropriate nutrition to pregnant inmates and what constitutes ‘appropriate nutrition’; and

Whereas, Texas fails to report all pregnant inmates’ pregnancies and outcomes; and

Whereas, The detrimental perinatal outcomes of inadequate prenatal care include up to a seven-fold increased risk for preterm delivery, increased risk for stillbirth, low birth weight, admission to the neonatal intensive care unit, short interpregnancy interval, and decreased odds of initiating breastfeeding or having an infant immunized; and

Whereas, Other states such as Pennsylvania, North Carolina, and Oklahoma have explicit standards of care for incarcerated pregnant mothers, such as specific lab tests, frequency of prenatal visits with an obstetrician, and screening for high-risk pregnancies; and

Whereas, In Policy 265.018, the Texas Medical Association, “strongly supports the standardization of a national set of evidence-based measures that are clinically meaningful and lead to performance improvement while improving both patient outcome and patient satisfaction”; and

Whereas, ACOG states care provided to pregnant inmates should follow the ACOG and AAP Guidelines for Perinatal Care and mechanisms to ensure implementation of these guidelines must be secured; therefore be it

RESOLVED, That our Texas Medical Association recognize the lack of uniform prenatal care provided to incarcerated pregnant women in Texas correctional facilities; and be it

RESOLVED, That TMA encourage the Texas Commission on Jail Standards and Texas Department of Criminal Justice to comply with evidence-based guidelines from national physician organizations regarding the care and management of incarcerated pregnant women in Texas correctional facilities; and be it

RESOLVED, That TMA encourage the Texas Commission on Jail Standards and Texas Department of Criminal Justice to report all pregnant inmates’ pregnancies and outcomes.
Related TMA Policy:
265.018 Evidence-Based Medicine and Practice

Related AMA Policy:
Standards of Care for Inmates of Correctional Facilities H-430.997
Health Care While Incarcerated H-430.986

References:
Texas Medical Association House of Delegates

Resolution 338
2021

Subject: Support for Immunization Information System Interjurisdictional Data Exchange

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Immunization information systems (IISs), or immunization registries, are computerized, confidential databases that record immunization doses administered by participating physicians and providers in a given jurisdiction; and

Whereas, IISs provide consolidated patient immunization histories across multiple physicians/providers and generate immunization reminders for patients and physicians/providers; and

Whereas, IISs provide aggregate data on vaccinations, allowing assessment of coverage levels and guiding public health action to reduce vaccine-preventable disease; and

Whereas, Individual states and regions currently maintain 64 IISs within the U.S., including Texas’ immunization registry, ImmTrac2; and

Whereas, Each IIS is subject to local, state, and federal laws and regulations for protection of health information, posing barriers to interjurisdictional data sharing; and

Whereas, Thirty-four of the 64 IISs have signed memorandums of understanding allowing interjurisdictional data exchange across IISs; and

Whereas, ImmTrac2 has not signed such a memorandum of understanding; and

Whereas, Texas does not permit interjurisdictional sharing of personal immunization data from ImmTrac2, instead allowing only aggregate, statistical data to be shared; and

Whereas, On average, people in the U.S. move more than 11 times in their lifetime, potentially leading to incomplete immunization records due to limited interjurisdictional immunization data exchange; and

Whereas, Incomplete immunization records lead to overvaccination and missed opportunities for vaccination, and pose challenges during multijurisdictional outbreaks when public health officials, physicians, and health care providers need to ascertain immunization status; and

Whereas, The National Vaccine Advisory Committee and the American Immunization Registry Association support and prioritize the improvement of IIS-to-IIS data exchange across jurisdictions; and

Whereas, American Medical Association Policy H-440.899 encourages states to develop comprehensive, lifespan immunization registries interfaced with other state registries; and

Whereas, The ongoing COVID-19 pandemic and immunization efforts have highlighted the need for interjurisdictional data on immunizations to ensure individuals receive appropriate, timely follow-up
doses of existing multidose vaccines even if individuals leave their state or region between doses; and
therefore be it

RESOLVED, That our Texas Medical Association support sharing Texas immunization registry
(ImmTrac2) data interjurisdictionally with other state and regional immunization information systems to
help ensure accurate and complete patient immunization records while maintaining patient privacy.

Related TMA Policy:
135.011 Immunization Registry for Texas
135.025 Improving the ImmTrac Registry by Reverting Back to an Opt-Out System
135.017 ImmTrac
135.021 Immunization Records
135.008 Immunizations Administering

Related AMA Policy:
Immunization Registries H-440.899
Establishment of a Network of State Immunization Registries D-440.961
Distribution and Administration of Vaccines H-440.877

References:
1. Immunization Information Systems (IIS): About Immunization Information. Centers for Disease
3. ImmTrac2 Registry Home. Texas Department of State Health Services (DSHS). Updated June 9,
8. National Vaccine Advisory Committee. NVAC Statement of Support Regarding Efforts to Better
   Implement IIS-to-IIS Data Exchange Across Jurisdictions: Approved by the National Vaccine
10. Feuer, W. Privacy concerns a challenge for Trump administration’s effort to track Covid
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 339
2021

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

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Texas’s 29 million residents are 40% Hispanic or Latino, 13% Black, 5% Asian, and 41% white non-Hispanic or -Latino, according to U.S. Census Bureau population estimates for 2019; and

Whereas, In a 2018 National Health Interview Survey, 13.8% of Black respondents and 12.3% of Hispanic or Latino respondents reported health in fair or poor conditions compared with only 8.3% of white respondents; and

Whereas, Statewide racial and ethnic disparities in health exist, with a 2017 Texas Department of State Health Services study indicating the African American population makes up 11.8% of the Texas population but 39.8% of the obese Texas population, while the white population makes up 41.9% of the Texas population and only 30.1% of the obese Texas population; and

Whereas, The ongoing COVID-19 pandemic has exacerbated statewide racial and ethnic disparities in health, with Hispanic Texans accounting for 49% of known COVID-19 fatalities in July despite making up only 40% of the state population, and Black Texans accounting for 14% of the fatalities despite only making up 12% of the state population; and

Whereas, The Texas Office of Minority Health Statistics and Engagement studied and worked to solve racial inequities across Texas’s health agencies prior to its defunding in the 2017 legislative session; and

Whereas, Advocates and state lawmakers have stated that had the Office of Minority Health Statistics and Engagement not been dismantled, Texas would have been in a better position to identify and take action on disparities in racial and ethnic health earlier in the COVID-19 pandemic and vaccine rollout; and

Whereas, The Office of Minority Health Statistics and Engagement fell within the oversight of the Texas Health and Human Services Commission, of which the Texas Department of State Health Services is a part; and

Whereas, The Texas Department of State Health Services initially struggled to collect and provide comprehensive information on race and ethnicity in early COVID-19 cases, limiting early information on COVID-19-related racial and ethnic disparities in health; and

Whereas, The Texas Department of State Health Services’ statewide COVID-19 vaccine rollout designates fewer vaccine distribution sites in majority Hispanic and Black areas in Harris, Dallas, and Travis counties, limiting vaccine accessibility for minority populations in major Texas counties; and
Whereas, American Medical Association Policy H-350.974 recognizes racial and ethnic health disparities as a major public health problem and prioritizes the elimination of racial and ethnic disparities in health care; and therefore be it

RESOLVED, That our Texas Medical Association support the Texas Department of State Health Services prioritizing continued efforts to address racial and ethnic disparities in health.

Related TMA Policy:
- 60.008 Rejection of Discrimination
- 50.012 Addressing Cancer Health Disparities
- 265.030 Social Determinants of Health

Related AMA Policy:
- Racial and Ethnic Disparities in Health Care H-350.974

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 340
2021

Subject: Supporting the Health of Undocumented Immigrants During the COVID-19 Pandemic and Future Pandemics

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, In 2016, Texas had an estimated 1.6 million undocumented immigrants, who comprised 33% of the immigrant population and 6% of the total population; and

Whereas, A 2020 study found that in Texas, approximately 32% of undocumented immigrants live below the poverty line and 64% are uninsured, limiting access to medical treatment; and

Whereas, Longstanding federal policies such as the five-year waiting period all immigrants, including undocumented immigrants, must follow to qualify for federally funded public benefits has impeded attempts to reduce the impact of COVID-19 on immigrant populations, specifically those who are undocumented; and

Whereas, Undocumented immigrants are more likely to be uninsured due to restrictions from participating in Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the Affordable Care Act (ACA) marketplaces; and

Whereas, Undocumented immigrants often live in multigenerational housing, which increases their risk for COVID-19 exposures; and

Whereas, Undocumented workers are at a disproportionately higher risk of contracting COVID-19 as they often hold essential, frontline jobs that put them at significant risk; and

Whereas, Undocumented immigrants often have low-to-moderate incomes with no regular medical care, making them more likely to delay seeking medical care for COVID-19; and

Whereas, Testing provided by the optional state Medicaid program in the Families First Act restricts COVID-19 testing to immigrants who are already eligible for Medicaid, which does not include undocumented immigrants; and

Whereas, While many fears have been quelled by the U.S. Citizenship and Immigration Services’ (USCIS) announcement that COVID-19 related testing, treatment, or preventive care will not count against aliens in the public charge analysis, financial barriers to care of undocumented individuals and fear of deportation are still prevalent; and

Whereas, Undocumented immigrants are often excluded from public assistance programs and have been excluded from stimulus payments and other benefits provided by COVID-19 relief bills; and

Whereas, The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) only covers COVID-19 testing for uninsured individuals, not their treatment costs; and
Whereas, The CARES Act extended funding for Community Health Centers and created reimbursement opportunities for health care providers facing lost revenue as a result of COVID-19, but providers are not required to take part and patients often have difficulty discerning which providers are currently participating; and

Whereas, In Texas, approximately 50% of undocumented immigrants lack English proficiency and are therefore less likely to receive and understand public health messages, warnings, and updates provided by the Centers for Disease Control and Prevention or state officials; and

Whereas, The Health Resources and Services Administration (HRSA) COVID-19 Uninsured Program only reimburses the cost of care for patients with a primary diagnosis of COVID-19 and does not cover the cost of follow-up care or care for secondary symptoms brought on by the virus; and

Whereas, If providers fail to submit a bill for a patient’s COVID-19 related treatment or testing to the HRSA COVID-19 Uninsured Program, the patient may be fully responsible for the bill; and

Whereas, According to Pew Research Center, more than 68% of American adults believe the country has a responsibility to expand health care access to combat COVID-19 and provide care to affected undocumented immigrants; and

Whereas, New Jersey and California provide free COVID-19 treatment to all individuals, regardless of insurance or immigration status; and

Whereas, Recent administrations stated all persons in the U.S., regardless of status, should have access to free COVID-19 services including testing, vaccinations as they become available, and hospitalization; and

Whereas, It has been estimated that approximately 50-80% of the population needs to be vaccinated to reach the herd immunity threshold for COVID-19, so excluding undocumented immigrants from vaccination distribution plans would undermine herd immunity, preventing the U.S. from recovering from the COVID-19 pandemic; and

Whereas, Expanding statewide COVID-19 coverage and reimbursements for undocumented children is supported by Texas Medical Association policy 55.057;28 and

Whereas, Providing COVID-19 testing, treatment, relevant follow-up appointments, vaccinations, and hospitalizations free of charge to undocumented immigrants in Texas is supported by TMA policy 110.006; therefore be it

RESOLVED, That the Texas Medical Association advocate for assistance for the reduction of language barriers by medical centers, community centers, free clinics, and physicians in the communication of COVID-19 and any future pandemic-associated information, testing, treatment, and vaccinations; and be it further

RESOLVED, That TMA support physician participation in any current and future pandemic-related government assistance programs such as the Health Resources and Services Administration (HRSA) COVID-19 Uninsured Program; and be it further

RESOLVED, That TMA support the distribution of life-saving vaccinations to all individuals in the community, including undocumented immigrants, during a pandemic in order to swiftly achieve herd immunity; and be it further
RESOLVED, That TMA support the allocation of additional funding for health care coverage of undocumented immigrants during any national pandemic.

Related TMA Policy:
- 55.057 Health Care of Undocumented Children
- 145.013 Private Healthcare System, Impact of Uninsured
- 110.006 Health Plan
- 260.103 Disaster Preparedness Planning and Response

Related AMA Policy:
- Health Care Payment for Undocumented Persons D-440.985
- Federal Funding for Safety Net Care for Undocumented Aliens H-160.956
- Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992
- Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
- Patient and Physician Rights Regarding Immigration Status H-315.966
- Financial Impact of Immigration on American Health System D-160.988

References:


2 https://www.texmed.org/Template.aspx?id=42728&terms=110.006*
Whereas, In May 2020, the U.S. surgeon general called for hospitals to consider stopping elective procedures during the COVID-19 outbreak to ensure adequate hospital space and resources for COVID-19 patients, leading many states to issue varied forms of restrictions on elective procedures; and

Whereas, Often a surgical procedure is designated as “elective” to distinguish between emergent and nonemergent cases though medically necessary procedures can fall under both forms of care; and

Whereas, Studies have shown that any delay in access to an “elective surgery” that is medically necessary can have a variety of harmful effects including, but not limited to, higher morbidity and mortality, reduced quality of life, reduced activity and mobility, and increased costs for the health system; and

Whereas, Multiple times during the ongoing COVID-19 pandemic, Texas Gov. Greg Abbott implemented bans on elective medical procedures and called for procedures that were not “immediately, medically necessary” to be barred temporarily; and

Whereas, In his July 9, 2020, executive order, Governor Abbott extended the suspension of nonemergent surgeries to more than 100 counties and asked that hospitals within certain trauma service areas “postpone surgeries and procedures that are not medically necessary to diagnose or correct a serious medical condition, or to preserve the life of a patient” and also stated that the suspension does not apply to “any surgery or procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete any hospital capacity needed to cope with the COVID-19 disaster”; and

Whereas, A March 22, 2020, executive order by Governor Abbott postponing all surgeries and procedures “not immediately necessary” resulted in confusion regarding the status of abortions as to whether they were considered elective procedures, which launched a legal battle within the state; and

Whereas, The confusion regarding how the call for a suspension of elective procedures applied to abortion resulted in decreased access to abortion services as some clinics shut down while awaiting a legal verdict on the matter; and

Whereas, The temporary restriction on access to abortion care created a gap in access to this care for many Texas women; one *Journal of the American Medical Association* study found the number of abortions in Texas declined by 38% during the executive order’s duration, while concurrently the number of out-of-state abortions increased by six-fold; and

Whereas, After Governor Abbott’s first executive order expired in May 2020, there was a 61% increase in second-trimester abortions in Texas; and
Whereas, The increase in second-trimester abortions likely reflects delays in care among those who waited for an appointment and facilities’ limited capacity to meet backlogged patient need as a result of the ban on elective procedures; and

Whereas, The American College of Obstetricians and Gynecologists released a joint statement in March 2020 stating that “[a]bortion is an essential component of comprehensive health care. It is also a time-sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or potentially make it completely inaccessible. The consequences of being unable to obtain an abortion profoundly impact a person’s life, health, and well-being,” and the American Medical Association, the World Health Organization, and the United Nations Population Fund issued similar statements of support; and

Whereas, There is a long history of discourse around the use of “elective” to describe abortion services for women even though delaying access to abortion prevents women from obtaining a previability abortion, which can increase the risk of medical complications by necessitating a surgical procedure later in the pregnancy course; and

Whereas, Texas Medical Association Policy 10.002 emphasizes early access and referral for abortion services, if indicated, and is generally supportive of abortion access; therefore be it

RESOLVED, That the Texas Medical Association amend TMA Policy 10.002 as follows:

Abortion, 10.002
The Texas Medical Association recognizes abortion as a legal and time-sensitive medical procedure, and the performance of abortion must be based upon early and accurate diagnosis of pregnancy; informed and nonjudgmental counseling; prompt referral to skillful and understanding personnel working in a good facility; reasonable cost; and professional follow up. (Remarks of Speaker, p 12, A-85; reaffirmed: Council on Public Health, p 105, I-89; Res. 28WW, p 218-D, A-92; Res. 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).

; and be it further

RESOLVED, That our TMA advocate against restrictions that limit access to any time-sensitive or medically necessary procedures for Texans.

Related TMA Policy:
55.004 Adolescent Sexual Activity
260.075 Preventive Health Care for Texas Women
260.103 Disaster Preparedness Planning and Response
260.037 Essential Public Health Services
260.105 Statewide Crisis Standards-of-Care

Related AMA Policy:
Abortion H-5.995
Support for Access to Preventive and Reproductive Health Services H-425.969
11.1.4 Financial Barriers to Health Care Access
References:

Whereas, More than 40% of Texas women live in Texas counties that do not have clinics which provide services for medical termination of pregnancy; and

Whereas, Current Texas Medical Association policy 260.037 “Essential Public Health Service” supports linking Texans to health care when it is otherwise unavailable; and

Whereas, Crisis pregnancy centers (CPCs) are marketed as medical centers specialized to help women obtain information and access procedures for family planning and pregnancy termination; and

Whereas, It is estimated that more than 2 million women nationwide seek services at CPCs annually, and, while many believe that CPCs improve access to family planning resources, CPCs provide incorrect and incomplete medical information, and actively discourage women from accessing the full range of pregnancy health care resources available; and

Whereas, The American Medical Association (AMA) has deemed CPCs unethical due to their practice of misrepresenting and misinterpreting medical evidence, and the lack of patient-centered care and licensed medical professionals available at CPCs; and

Whereas, CPCs have been found to spread inaccurate information about abortion, including claims that suggest abortion leads to an increased risk of breast cancer and may cause emotional or psychological distress and infertility; and

Whereas, CPCs may take advantage of the lack of public knowledge on recent restrictions on abortion and use manipulative tactics to extend their visitors’ pregnancies to the point where abortion is difficult, if not impossible, to access in Texas; and

Whereas, CPC volunteers may convince visitors to delay or postpone their appointments, give fake due dates, or overstate the possibility of miscarriage to convince them to not have an abortion; and

Whereas, CPCs target abortion-minded women by employing online tactics so that their clinics are shown in search results when women look up abortion clinics; and

Whereas, A 2016 study in the Journal of Pediatric and Adolescent Gynecology found inaccurate and misleading information on CPC websites and advised that state governments forego listing CPCs in state directories; and

Whereas, The Texas Health and Human Services Commission (HHSC) list of “Agencies Offering Free Obstetric Sonograms” exclusively lists CPCs, rather than licensed health care providers, lending legitimacy to the flawed information that CPCs distribute; and
Whereas, CPCs, such as those listed by HHSC, are often religiously affiliated and make prayer or proselytization a key part of their services, even though many receive federal and state funding and are thus prohibited from including religion as part of their service provision; and

Whereas, The practice of listing CPCs on the HHSC website is in direct opposition to TMA policy 10.003 “Patient Autonomy and Accuracy of Information in Informed Consent for Abortion”, a policy which urges HHSC to distribute evidence-based information to women inquiring about abortion; and

Whereas, TMA policy 260.075 “Preventive Health Care for Texas Women” states that TMA will serve as a partner to the state in ensuring transparent operation of the states' women's health and family planning programs; therefore be it

RESOLVED, That TMA advocate for increased transparency at crisis pregnancy centers.

Related TMA Policy:
- 10.002 Abortion
- 10.003 Patient Autonomy and Accuracy of Information in Informed Consent for Abortion
- 260.037 Essential Public Health Services
- 260.075: Preventive Health Care for Texas Women

Related AMA Policy:  
- Abortion H-5.995

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 343
2021

Subject: Study to Improve Healthcare Access and Care for Persons with Disabilities

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, 22.2% of adults in the United States reported a disability as of 2013; and
Whereas, The American with Disabilities Act defines a disability as a mental or physical impairment that has an effect on the individual’s ability to carry out major life activities; and
Whereas, Those with disabilities are four times more likely to report poorer health compared with their nondisabled counterparts, and this number is increased in minorities with disabilities; and
Whereas, Individuals with a disability also are less likely to receive health care screenings compared with their nondisabled counterparts; and
Whereas, COVID-19 has increased barriers to health care faced by people with disabilities; examples are patients with intellectual/developmental disabilities being left alone in a hospital due to visitor bans and those who are deaf or hard of hearing being denied effective communication; and
Whereas, A report generated on the Association of American Medical Colleges Curriculum Inventory, 2015-16, demonstrated that many medical schools did not explicitly address disabilities in their curriculum; and
Whereas, Previous studies indicated that the current medical education system does not adequately train students to provide care for people with disabilities; and
Whereas, The U.S. surgeon general released a Call to Action to Improve the Health and Wellness of Persons With Disabilities and identified that a failure of medical education programs to teach about disability was a root cause for decreased health status and resources to maintain wellness; and
Whereas, Studies show that physicians and students in medical and health professions harbor negative attitudes about and show discomfort with treating people with disabilities; and
Whereas, A study of the effects of educating medical students about patients with disabilities showed the education positively impacted the students’ opinions and increased their overall knowledge; and
Whereas, The World Health Organization stated that one of the largest barriers to care for those with disabilities is the lack of training on the topic among health care professionals; and
Whereas, The Texas Medical Association has no policy supporting education of physicians about patients with disabilities and no committees to review laws, regulations, and activities that affect the disabled community; and
Whereas, TMA has a variety of committees aimed at promoting and protecting the rights of specific groups such as the committees on Reproductive, Women’s and Perinatal Health; Child and Adolescent Health; and Patient-Physician Advocacy, but none focused on advocacy for Texas’ enormous population of people with disabilities; therefore be it

RESOLVED, That our Texas Medical Association study and recommend actions to address the following issues related to patients with disabilities: (1) identification of problems that lead to poor health outcomes in people with disabilities; (2) how to improve health outcomes for patients with disabilities; (3) ways to increase health care screenings among patients with disabilities; (4) how to improve training in medical schools and residency programs related to caring for patients with disabilities; and (5) how TMA can best educate its members about caring for patients with disabilities, including reviewing laws, regulations, and activities that impact the disability community; and be it further

RESOLVED, That the results of this study be reported back to the TMA House of Delegates at TexMed 2022.

Related TMA Policy:
60.008 Rejection of Discrimination
200.040 Joint Admission Medical Program
200.031 Medical School Admissions

Related AMA Policy:
Establishment and Function of Sections G-615.001
Minorities in the Health Professions H-350.978

References:
1. Approaches to Training Healthcare Providers on Working with Patients with Disabilities. Association of University Centers on Disabilities; Alliance for Disability in Health Care Education.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 344
2021

Subject: Supporting Mature Minors Ability To Receive Vaccinations Without Parental Consent

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The World Health Organization listed vaccine hesitancy as a top 10 threat to global health in 2019; and
Whereas, There has been an increase in individuals who do not believe in vaccinations (anti-vaxxers) and vaccine hesitancy across the United States; and
Whereas, In 2019, there were 1,282 cases of measles confirmed across 31 states, which is the largest number of cases reported since 1922; and
Whereas, Texas is ranked 48th on WalletHub's 2020 list of state vaccination rates, and Texas is ranked number one in hotspots for vaccine exemption by the Texas Medical Association; and
Whereas, Harris, Tarrant, Collin, and Travis County rank among the top 15 metropolitan areas in the nation with the highest number of kindergartners who are not vaccinated due to nonmedical reasons; and
Whereas, Texas has experienced a 20-fold increase in K-12 students (an increase of 2,314 to approximately 45,000 students) receiving exemptions from vaccinations and an increase from 0.45% to 1.35% in conscientious exemptions for vaccinations from 2003 to 2016; and
Whereas, It is well known that parents who are against vaccinations often make a choice for their child's health that puts the child in danger; and
Whereas, Research has shown that the anti-vaccination movement is driven by misinformation by media, conspiratorial thinking, and mistrust of government; and
Whereas, Media misinformation has historically resulted in decreased administration of essential vaccines, such as the pertussis vaccination decrease from 81% in 1974 to 31% in 1980 in the United Kingdom, which resulted in a pertussis outbreak; and
Whereas, Research indicates that, albeit the refutation of misleading or false studies, childhood vaccination rates remain decreased following the spread of misinformation; and
Whereas, Statistical analysis of YouTube videos discussing and related to vaccination find that 32% of videos opposed vaccination and that these videos had more views and higher ratings than videos that depicted vaccinations positively; and
Whereas, All states acknowledge the autonomous role older children should have in their health decisions and minors are permitted to consent for their own health care in certain cases such as marriage, emancipation, family planning, and STD treatment; and
Resolved, That the Texas Medical Association support a physician’s right, if deemed appropriate by the state, to provide vaccinations to mature minors who provide consent; and be it further

Resolved, That TMA will encourage physicians to have age-appropriate materials for vaccine information and documentation methods for minors considering obtaining a vaccination; and be it further

Resolved, That TMA encourage our legislature to support model legislation expanding access to vaccines by broadening the rights of mature minors who comprehend the need for, nature of, and any
risks inherent to a vaccination to be able to give informed consent to receive a vaccination recommended by the U.S. Advisory Committee on Immunization Practices.

Related TMA Policy:
1. **135.012 Immunization Rates in Texas**
2. **50.011 Physician Role in Increasing Vaccination for HPV**
3. **260.072 Conscientious Objection to Immunizations**
4. **135.022 Adolescent Parent Immunizations**

Related AMA Policy:
5. **Model Legislation for "Mature Minor" Consent to Vaccinations D-440.926**
6. **Education and Public Awareness on Vaccine Safety and Efficacy H-440.830**
7. **National Immunization Program H-440.992**
8. **2.2.1 Pediatric Decision Making**

References:


RESOLVED, That the Texas Medical Association develop an Official Statement on Racism; and be it further

RESOLVED, That comprehensive policy be developed to support the statement and ensure that anti-racism and health equity strategies are prioritized for inclusion in organizational, educational, and advocacy activities; and be it further

RESOLVED, That TMA support identifying racism as a public health emergency.
Related TMA Policy:

- 50.012 Addressing Cancer Health Disparities
- 60.008 Rejection of Discrimination
- 185.012 Physician Recruitment
- 115.015 Accountable Care Organizations
- 115.021 Principles for Community-Based Accountable Care Organizations
- 200.022 Medical Education Admissions
- 260.029 Preventive Medicine.
- 265.030 Social Determinants of Health
- 330.015 Physician-Led Initiatives to Address Maternal Mortality and Morbidity
- 330.013 Maternal Mortality Review

Related AMA Policy Statement:

In June 2020, the AMA Board of Trustees acknowledged the health consequences of violent police interactions and denounced racism as an urgent threat to public health, pledging action to confront systemic racism, racial injustice and police brutality.

The new policy approved by the AMA, representing physicians and medical students from every state and medical specialty, opposes all forms of racism as a threat to public health and calls on AMA to take prescribed steps to combat racism, including: (1) acknowledging the harm caused by racism and unconscious bias within medical research and health care; (2) identifying tactics to counter racism and mitigate its health effects; (3) encouraging medical education curricula to promote a greater understanding of the topic; (4) supporting external policy development and funding for researching racism’s health risks and damages; and (5) working to prevent influences of racism and bias in health technology innovation.

“The AMA recognizes that racism negatively impacts and exacerbates health inequities among historically marginalized communities. Without systemic and structural-level change, health inequities will continue to exist, and the overall health of the nation will suffer,” said AMA Board Member Willarda V. Edwards, M.D., M.B.A. “As physicians and leaders in medicine, we are committed to optimal health for all, and are working to ensure all people and communities reach their full health potential. Declaring racism as an urgent public health threat is a step in the right direction toward advancing equity in medicine and public health, while creating pathways for truth, healing, and reconciliation.”

Though previous AMA policies and principles have emphasized the need to eliminate health disparities and called on physicians to prevent violence of all kinds, the new policy explicitly acknowledges racism’s role in perpetuating health inequities and inciting harm against historically marginalized communities and society as a whole.

Specifically, the new policy recognizes racism in its systemic, cultural, interpersonal, and other forms as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care. It makes clear that a proactive approach to prevent, or identify and eliminate, racism is crucial—particularly considering that studies show historically marginalized populations in the U.S. have shorter lifespans, greater physical and mental illness burden, earlier onset and aggressive progression of disease, higher maternal and infant mortality, and less access to health care.

The policy describes the various forms of racism as follows:

- **Systemic racism**: structural and legalized system that results in differential access to goods and services, including health care services.
• **Cultural racism**: negative and harmful racial stereotypes portrayed in culturally shared media and experiences.

• **Interpersonal racism**: implicit and explicit racial prejudice, including explicitly expressed racist beliefs and implicitly held racist attitudes and actions based upon or resulting from these prejudices.

In addition, the new policy requests AMA to identify a set of best practices for health care institutions, physician practices, and academic medical centers to address and mitigate the effects of racism on patients, providers, international medical graduates, and populations. It also guides the AMA’s position on developing and implementing medical education programs that generate a deeper understanding of the causes, influences and effects of all forms of racism—and how to prevent and improve the health effects of racism.

Further, the policy asks that AMA support the creation of external policy to combat racism and its effects and encourage federal agencies and other organizations to expand research funding into the epidemiology of risks and damages related to racism. Additionally, the policy asserts that the AMA will work to prevent, and protect against the influences of racism and bias in innovative health technologies.

The AMA has been leading an aggressive effort to embed equity in thoughts, actions, and processes so as not to perpetuate inequities and instead help people live healthier lives. In 2018, the AMA adopted policy to define health equity and outline a strategic framework toward achieving optimal health for all. To help navigate these challenges, in 2019 the AMA hired its first chief health equity officer to establish the AMA’s Center for Health Equity to elevate and sustain efforts to address systemic level changes that can improve health.

Fully understanding that there is tremendous work still to be done to ensure that everyone has the opportunity, conditions, resources, and power to achieve optimal health, the AMA is committed to collaborating with stakeholders to confront the issue of racism within our society. The AMA continues to urge other leading health organizations to also take up the mantle of intolerance for racism as it pushes upstream to dismantle racism across all of health care — driving the future of medicine toward anti-racism.

**References:**

AAFP Statement on Racism

The American Academy of Family Physicians (AAFP) recognizes that racism is a system that categorizes people based on race, color, ethnicity and culture to differentially allocate societal goods and resources in a way that unfairly disadvantages some, while without merit, rewards others. As a system, racism has been institutionalized in a way that permits the establishment of patterns, procedures, practices and policies within organizations that consistently penalizes and exploits people because of their race, color, culture or ethnic origin. The system of racism affects the attitudes, beliefs and behaviors of one individual towards another (personally-mediated) as well as how individuals perceive themselves (internalized).

The AAFP also recognizes the impact of racism within the U.S. health care delivery system, which has historically engaged in the systematic segregation and discrimination of patients based on race and ethnicity, the effects of which persist to this day. Hospitals and clinics, which were once designated for racial and ethnic minorities, continue to experience significant financial constraints and are often under-resourced and improperly staffed. These issues result in inequities in access to and quality of health care and are major contributors to racial and ethnic health disparities. While segregation and discrimination based on race and ethnicity is no longer legal today, some organizations continue to discriminate based on insurance status, which also disproportionately impacts non-white populations.
The AAFP opposes all forms of institutional racism and supports family physicians to actively work to dismantle racist and discriminatory practices and policies in their organizations and communities. The AAFP recommends that all health care systems, hospitals, clinics and institutions adopt anti-racist policies that advocate for individual conduct, practices and policies that promote inclusiveness, interdependence, acknowledgment and respect for racial and ethnic differences. The AAFP also recommends that organizations take an active approach to dismantling racism by conducting a comprehensive critical examination of policies and procedures, empowering the development of diverse formal and informal leadership at all levels and developing a plan that increases accountability, demonstrates transparency and reorganizes power. (July 2019 BOD) (2019 COD)

ACOG Statement on Racial Bias
Policy & Position Statements
Statements of Policy
There is a growing body of literature that validates the public health impact of racial bias, implicit and explicit, on the lives and health of people of color. As women’s health care physicians, obstetrician-gynecologists (ob-gyns) must work to clearly understand the impact of racial bias and how it manifests in our lives and in the lives of our patients.

Racial bias is an issue that affects our patients, either directly by subjecting them or their families to inequitable treatment, or indirectly by creating a stressful and unhealthy environment. It is critical that physicians are aware of this reality for patients of color regardless of the patient’s financial position.

Many professions, including medicine, are beset by implicit and explicit racial bias. Medicine, including the field of obstetrics and gynecology, has engaged in practices that were very harmful to women of color. These practices include performing experimental gynecologic surgery on enslaved women in the mid-1800s and the testing of high-dose hormonal contraceptives on Puerto Rican women and other women of color in the 1950s. More recently, from 2005 to 2013, numerous incarcerated women in California, who are disproportionately women of color, were sterilized without lawful consent.

In less obvious ways, implicit bias may affect the way ob-gyns counsel patients about treatment options such as contraception, vaginal birth after cesarean, and the management of fibroids. Implicit biases are subconscious assumptions we all make about the world around us. They are formed from our life experiences – who we are, how and where we grew up, who our friends and family are – and all of these experiences influence how we view and interpret the world. Implicit bias has been documented to affect the patient-physician relationship as well as treatment decisions and outcomes. It is our duty to acknowledge that implicit bias affects how we take care of women and to consciously ensure that we treat all patients equitably.

The racial and ethnic disparities in women’s health (including higher rates of preterm birth, maternal mortality, and breast, cervical, and endometrial cancer deaths among Black women) cannot be reversed without addressing racial bias, both implicit and explicit. We recognize that structural and institutional racism contribute to and exacerbate these biases, which further marginalize women of color in the health care system. Without acknowledging the historical context from which these disparities grew, and examining these disparities through a lens that takes into account race, gender, and class, an equitable health care system that serves all women cannot be realized.

The history and daily experiences of our patients of color may negatively affect their perceptions of the health care system. This may be manifested as mistrust of health care providers, avoidance of care, and not following medical advice. As ob-gyns, we must stand up against policies that disadvantage women and show our patients that we will not tolerate discrimination based on race, color, national origin, disability, age, religion, marital status, sexual orientation, perceived gender, or any other basis.
Further, the American College of Obstetricians and Gynecologists is committed to addressing racial bias and discrimination and their impact on our patients. Below are examples of how women’s health care physicians can work to confront these issues:

• Be aware of one’s own biases when caring for patients
• Perform research on how biases, implicit and explicit, and discrimination are associated with health outcomes in women
• Conduct research with improved outcomes for women of color as a primary objective
• Integrate issues of racial injustice, including recognition of provider bias, into our teaching of students, residents, fellows, and practitioners
• Engage with activists and advocates within communities of color to foster communication about addressing health disparities
• Examine and address the ways health care systems perpetuate inequity in communities of color
• Encourage racial and ethnic diversity at all levels of our profession, from medical school to residency to practice to leadership positions at the American College of Obstetricians and Gynecologists
• Create an Alliance for Innovation on Maternal Health (AIM) disparity bundle for obstetrics

Racial bias is an issue that affects our patients and our colleagues. We must commit to working together to address this issue and create an equitable health care system that serves all women. Our patients deserve no less.

References

Approved by the Executive Board, February 2017

Additional Resources:
Williams, DR, Jackson PB Social Sources of Racial Disparities in Health. Health Affairs 2005 Mar-Apr;24(2):325-34.

DuBois Review: Social Services Research on Race: Vol 8(1) Special Issue on Racial Inequality and Health (The whole document but specifically “Conceptualizing Racial Disparities in Health: Advancement of a Socio-Psychobiological Approach”).

Whereas, Most immigrants live in just 20 metropolitan areas in the United States, and health care professionals in safety-net settings in these areas likely will encounter patients who are deeply impacted by immigration policies in manners that affect their access to care; and

Whereas, An undocumented immigrant is defined as someone who crossed a United States border without authorization or who is not living within the terms of an entry visa or other authorization; and

Whereas, The immigration enforcement priorities of the Trump administration and the U.S. Department of Justice have had a negative impact on health care access for documented and undocumented immigrants, as well as for U.S. citizens in mixed-status families, by inciting fear that interaction with the health care system will result in detention or deportation; and

Whereas, More specifically, the federal public charge regulation that went into effect Feb. 24, 2020, only amplifies the fears of immigrants when interacting with the health care system because it allows federal officials to take into account when determining application status whether an applicant for permanent residency used health-related programs, such as Medicaid or the Supplemental Nutrition Assistance Program; and

Whereas, Immigrants face several unique barriers to accessing health care, including adequately conveying their symptoms and medical history, which can be alleviated by training physicians and medical providers to recognize cultural and language barriers; and

Whereas, Physicians and health care providers are not required by law to report individuals who are undocumented to legal authorities and may refuse to provide information about patients to law enforcement officers unless an active warrant for a specific individual covers that information; and

Whereas, Hospitals and other health care facilities are considered “sensitive locations” where immigration enforcement agencies are to avoid action without prior approval or a warrant; and

Whereas, Educating physicians on the rights of immigrants pursuing health care can help improve the quality of care delivered to members of this population and reduce their reluctance to seek care; therefore be it

RESOLVED, That our Texas Medical Association advocate for the adoption of policies by health care facilities that protect the rights of immigrants when seeking care, such as those that designate private areas of the clinic and discourage the routine collection of patient immigration status information; and be it further
RESOLVED, That our TMA launch an educational campaign advising patients about their rights when seeking medical care, such as their right to refuse to answer questions from immigration agents and to insist that their lawyer be present if they are questioned.

**Fiscal Note:** TBD

**Relevant TMA Policy:**
55.057 Health Care of Undocumented Children

**Relevant AMA Policy:**
H-315.966 Patient and Physician Rights Regarding Immigration Status
D-160.921 Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare
H-350.957 Addressing Immigrant Health Disparities
D-440.927 Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services
H-440.876 Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients
H-290.983 Support of Health Care to Legal Immigrants

**References:**
Texas Medical Association House of Delegates

Resolution 347
2021

Subject: Increasing Education Regarding the Effects of Bias and Discrimination on Patients Experiencing Homelessness

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Based on the Community Point-in-Time count reported to the U.S. Department of Housing and Urban Development in January 2019, 25,848 individuals were experiencing homelessness in Texas; and

Whereas, The COVID-19 pandemic’s detrimental effects on the economy have led to a rise in unemployment in Texas from 3.5% in February 2020 to 8.3% in September 2020, leading to an increase in risk of eviction and homelessness for many Texans; and

Whereas, Homelessness is a driver of poor health outcomes and is associated with a shorter life expectancy by 12 years, higher morbidity, and higher rates of emergency department visits and hospitalizations; and

Whereas, Many homeless individuals are also at high risk for having comorbid physical or mental health conditions, or substance use disorders; and

Whereas, In addition to the stigma faced by individuals with mental health conditions or substance use disorders, homeless people frequently report feeling unwelcome in encounters with physicians and staff, and these negative experiences are detrimental to their trust in the health care system and desire to seek future health services; and

Whereas, Social triage, stigmatization, a nonsystem for health care for the homeless, disrespect, feeling invisible to physicians and health care providers, and delayed medical care secondary to lacking essential resources are common themes described by individuals facing homelessness; and

Whereas, Studies have shown these feelings of discrimination are related to suboptimal treatment plans, such as overprescription for mental health disorders, inadequate pain management, or outright denial of care; and

Whereas, The Health Stigma and Discrimination Framework supports a multicomponent intervention including supporting individuals facing stigma, educating community members on harmful preconceptions, increasing policy-oriented advocacy, and training relevant professionals on appropriate harm-reducing strategies of care as various interventions to decrease stigma; and

Whereas, Effective stigma-reduction strategies can be implemented from the individual to the organizational level through new training programs, patient-centered policy change, education, and advocacy; and

Whereas, Providing educational interventions, increasing meaningful contact with the stigmatized population, increasing peer services, advocating for this population, and effecting legislative and policy
change have proven effective in other interventions, such as those aimed to reduce stigma against individuals with mental health illnesses; and

Whereas, The American College of Obstetricians and Gynecologists recognizes a physician’s role in improving health outcomes of homeless patients by screening for patients who may be homeless or at risk of being homeless, educating patients about community resources, providing equitable medical care, and offering preventive care; and

Whereas, A shorter hospital length of stay and the identification of payer sources for homeless patients (such as Medicaid) have been identified as benefits of routinely screening for homelessness as a social determinant of health in the emergency department; and

Whereas, The American Medical Association supports screening for social determinants of health and is collaborating with UnitedHealthcare to create 23 new ICD-10 codes related to social determinants to ensure individual needs are met; and

Whereas, Failure to identify and address social determinants of health and to promote evidence-based efforts to address the root cause of homelessness, such as housing-first initiatives, leads to inefficient spending and perpetuates economic burden; and

Whereas, The U.S. Interagency Council on Homelessness’ latest national research agenda recognizes the need for more research focused on improving health, well-being, and stability of homeless individuals; therefore be it

RESOLVED, That our Texas Medical Association recognize individuals facing homelessness suffer significant barriers in accessing health care that result in health care disparities; and be it further

RESOLVED, That our TMA encourage the use of multicomponent stigma-reduction interventions, including but not limited to increased education and advocacy to reduce the harmful effects of discrimination and promote health equity for patients experiencing homelessness; and be it further

RESOLVED, That our TMA support the use of standardized social determinants of health screenings to address the issue of housing status such that patients experiencing homelessness can receive care tailored to their specific situations; and be it further

RESOLVED, That our TMA encourage further research on how barriers to care negatively impact outcomes of patients experiencing homelessness.

Relevant TMA Policy:
None.

Relevant AMA Policy:
The Mentally Ill Homeless H-160.978
Eradicating Homelessness H-160.903
Increased Access to Identification Cards for the Homeless Population H-160.894
Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
References:

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 348
2021

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

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, The University Interscholastic League already has established the importance of athletic
preparticipation physical examinations by requiring them for school-based athletics; and

Whereas, Children and adolescents are developmentally different from the adult population and have very
different physical attributes depending on age and different nutritional, psychological, physical,
emotional, and developmental needs; and

Whereas, Because of their extensive training, physicians are best qualified to conduct athletic
preparticipation physical examinations; and

Whereas, The Texas Medical Association has established policy (55.056) supporting changes to the Texas
Education Code requiring that athletic preparticipation physicals for school-age children be conducted
only by licensed physicians or appropriately supervised physician assistants or advanced practice nurses
licensed in Texas; and

Whereas, Some school districts in Texas allow nonphysician practitioners to conduct athletic
preparticipation physicals; therefore be it

RESOLVED, That the Texas Medical Association advocate for legislative changes to the Texas
Education Code as described in TMA Policy 55.056 requiring that athletic preparticipation physical
examinations for school-age children be conducted only by licensed allopathic or osteopathic physicians,
or appropriately supervised physician assistants or advanced practice nurses licensed in Texas.

Related TMA Policy:

55.056 Physician Examinations for Young Athletes
55.046 Recommendations for Ensuring the Health of the Adolescent Athlete
30.004 Allied Health
30.012 Nursing and Nurses with Advanced Training
30.015 Nurses in Advanced Practice
30.016 Physician Assistants and Allied Health Personnel
30.025 Allied Health Care Professionals
30.029 Physician Extenders in Rural Health Clinics
30.035 Federal Prohibition of the Independent Practice of Medicine by Nurse Practitioners
30.036 Opposition to New State Licensing Category for Physicians Who Do Not Complete Residency
Training
55.006 School-Based Health Care Centers
Information:

From the Texas Education Code, Title 2. Public Education, Subtitle F. Curriculum, Programs and Services, Chapter 33. Service Programs and Extracurricular Activities:

Sec. 33.096. CARDIAC ASSESSMENTS OF HIGH SCHOOL PARTICIPANTS IN EXTRACURRICULAR ATHLETIC ACTIVITIES. (a) A school district must provide a district student, who is required under University Interscholastic League rule or policy to receive a physical examination before being allowed to participate in an athletic activity sponsored or sanctioned by the University Interscholastic League, the following:

(1) information about sudden cardiac arrest and electrocardiogram testing; and
(2) notification of the option of the student to request the administration of an electrocardiogram, in addition to the physical examination.

(b) A student may request an electrocardiogram from any health care professional, including a health care professional provided through the student’s patient-centered medical home, as defined by Section 533.0029, Government Code, a health care professional provided through a school district program, or another health care professional chosen by the parent or person standing in parental relation to the student, provided that the health care professional is:

(1) appropriately licensed in this state; and
(2) authorized to administer and interpret electrocardiograms under the health care professional’s scope of practice, as established by the health care professional’s Texas licensing act.

(c) The University Interscholastic League shall adopt rules as necessary to administer this section.

(d) The rules adopted under Subsection (c) must include:

(1) criteria under which a school district may request an exemption from the requirements of Subsection (a);
(2) variances that allow for a delay of the implementation of the requirement to notify students of the option to request an electrocardiogram under this section;
(3) procedures to ensure students receiving the required annual physical examination are notified of the option to request an electrocardiogram; and
(4) provisions to ensure that the requirements under this section are minimum standards that provide a school district with the option to implement a program that exceeds the standards required by this section.

(e) This section does not create a cause of action or liability or a standard of care, obligation, or duty that provides a basis for a cause of action or liability against a health care professional described by Subsection (b), the University Interscholastic League, a school district, or a district officer or employee for:

(1) the injury or death of a student participating in or practicing for an athletic activity sponsored or sanctioned by the University Interscholastic League based on or in connection with the administration or interpretation of or reliance on an electrocardiogram; or
(2) the content or distribution of the information required under Subsection (a) or the failure to distribute the required information under this section.

Added by Acts 2019, 86th Leg., R.S., Ch. 1023 (H.B. 76), Sec. 1, eff. September 1, 2019.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 349
2021

Subject: Reducing Intimate Partner Homicide

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Gun violence is widely acknowledged as a major public health issue, and the Texas Medical Association recognizes prevention of gun violence as a priority that requires the development of evidence-based strategies (TMA Policy 260.015); and

Whereas, Two-thirds of Texans killed by an intimate partner in 2019 were killed by a firearm; and

Whereas, Since the onset of COVID-19, domestic violence calls in the U.S. to police and shelters have increased by an estimated 6% to 12%, and Google searches for help with domestic violence have spiked by 75%; and

Whereas, Under federal law, possession of firearms is a crime for individuals convicted of misdemeanor domestic violence offenses; however, notable gaps in the law allow for individual state-based interpretations; and

Whereas, Under Texas Penal Code Ann. §§22.01 and 46.04(b), Texas prohibits firearm possession by domestic violence misdemeanants for no longer than five years following release from confinement or community supervision, and

Whereas, In Texas and other states that have low weapon regulation and high firearm prevalence, rates of intimate partner homicide (IPH) from firearms are greatest; and

Whereas, Firearms account for more than half of all female IPHs, and access to firearms is considered the greatest risk factor for IPH, increasing the likelihood by approximately 11 times; and

Whereas, Laws that use high-risk individuals (e.g., those convicted of intimate partner violence) as a criterion for gun removal reflect an approach that seeks to remove a lethal weapon before it becomes part of the abuse; and

Whereas, American Medical Association Policy H-145.972 considers high-risk domestic violence perpetrators to be individuals with domestic violence restraining orders or misdemeanor convictions of domestic violence crimes or stalking, supports the prohibition of this subgroup from possessing or purchasing firearms, and calls on states to adopt protocols or processes for the required removal of firearms by prohibited individuals; and

Whereas, Based on a study investigating temporal trends among 45 U.S. states, restricting access to firearms in individuals with a history of violent misdemeanors reduced IPH rates by 23%; and

Whereas, State laws that prohibit access to firearms for those with intimate partner violence-related restraining orders reduced IPH rates by 9.7%; and
Whereas, State laws that require relinquishment of firearms by those who are high risk for committing intimate partner violence, such as those with domestic violence misdemeanors and domestic violence restraining orders, reduced rates of IPH by 14%; and

Whereas, Stricter firearm policies aimed at reducing IPH are widely supported among Texans; 79% of Texans surveyed supported requiring all convicted domestic abusers to turn in their guns, and 77% supported requiring all convicted stalkers to turn in their guns; therefore be it

RESOLVED, That the Texas Medical Association support Texas law being consistent with federal law in declaring possession of a firearm unlawful for an individual convicted of intimate partner violence; and it be further

RESOLVED, That TMA support efforts to establish guidelines for removal of firearms from those at high risk for committing intimate partner violence, such as people with domestic violence misdemeanors and those convicted of stalking.

Related TMA Policy:
260.015 Firearms

Related AMA Policy:
Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Firearms and High-Risk Individuals H-145.972
Firearm Availability H-145.996
Firearm Related Injury and Death: Adopt a Call to Action H-145.973
Gun Regulation H-145.999
Family and Intimate Partner Violence H-515.965

References:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 350
2021

Subject: Restricting School Immunization Exemptions to Exemptions for Medical Reasons

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Texas kindergarten vaccination coverage rates have decreased in the past decade from 99.3% in the 2011-12 school year to 96.9% in the 2018-19 school year; and

Whereas, While TMA opposes conscientious objections to immunizations (TMA Policy 260.072), unvaccinated children in Texas during the 2019-20 school year were 20 times more likely to be unvaccinated as a result of a conscientious exemption than of a medical exemption; and

Whereas, A 2020 study found that Texas ranked 48th in the U.S. in overall vaccination rates and 49th in child and teenage vaccinations; and

Whereas, States that provide exemptions for religious beliefs and other nonmedical reasons harbor increased rates of vaccine-preventable diseases compared with those that do not; and

Whereas, Parents in Texas can obtain vaccine exemptions for their children for reasons of conscience simply by requesting an affidavit and submitting the notarized affidavit; and

Whereas, Although data still demonstrate high rates of vaccine coverage overall in the U.S., spatial clustering of American citizens seeking nonmedical exemptions leads to decreased herd immunity and has resulted in disease outbreaks; and

Whereas, Throughout the U.S. in 2019 alone, there were 1,282 individual confirmed cases of measles in 31 separate states, the largest outbreak since 1922; and

Whereas, California passed a bill in 2016 abolishing nonmedical exemptions from required vaccinations after a measles outbreak, leading to a 3.3% increase in statewide measles-mumps-rubella vaccinations; and

Whereas, In 2016, Mississippi achieved the highest vaccination rate in the U.S. by eliminating nonmedical exemptions and reinforcing the idea that nonmedical exemptions would violate the 14th amendment by rendering exempt children a hazard to other students; and

Whereas, Mississippi and West Virginia, which do not allow nonmedical immunization exemptions, did not report a measles outbreak in 2019, and Mississippi has not had a measles outbreak since 1992; and

Whereas, Misinformation spread via social media has increased vaccine hesitancy and belief in refuted side effects, contributing to an increase in requests for nonmedical exemptions from vaccines; and

Whereas, American Medical Association Policy H-440.970 does not support nonmedical exemptions for immunizations because they risk endangering vulnerable populations, and supports legislation that does not allow nonmedical exemptions for immunizations; and therefore be it
RESOLVED. That our Texas Medical Association advocate for the removal through legislation of nonmedical exemptions from required school vaccinations.

**Related TMA Policy:**
1. 135.012 Immunization Rates in Texas
2. 260.072 Conscientious Objection to Immunizations

**Related AMA Policy:**
1. Education and Public Awareness on Vaccine Safety and Efficacy H-440.830
2. Nonmedical Exemptions from Immunizations H-440.970
3. Childhood Immunizations H-60.969
4. Meningococcal Vaccination for School Children H-60.923
5. Achieving National Adolescent Immunization Goals H-440.901
6. HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

**References:**
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 351
2021

Subject: Support of a Statewide Contact Tracing App

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The Center for Disease Detection describes contact tracing as the process of tracking individuals who have been exposed to an infected person; and

Whereas, The use of contact tracing during the COVID-19 pandemic has been proven effective in decreasing the spread of the virus; and

Whereas, The success of the contact tracing strategy depends largely on the rapid detection of cases and isolation of contacts to prevent overwhelming the medical system; and

Whereas, The Texas Department of State and Health Services (DSHS) has a contact tracing workforce made up of recently hired personnel and continues to face challenges including lack of staffing and training; and

Whereas, In April 2020, the U.S. had employed only 0.5% of the estimated number of needed contact tracers, and Texas does not meet the estimated need for contact tracers; and

Whereas, Contact tracing apps can address the shortage of contact tracers, reduce overall costs, increase the speed of contact tracing, and complement traditional contact-tracing methods; and

Whereas, App-based contact tracing alone was superior to human-oriented contact tracing at reducing the spread of COVID-19 (6% to 17% decrease vs. 2% to 5% decrease), even with app usage as low as 20%; and

Whereas, The current low adoption rate of contact tracing apps across the U.S. can largely be attributed to a lack of advertising and digital privacy concerns; and

Whereas, Apple and Google have co-created an application programming interface (API) that uses wireless signals to anonymously detect when two phones are in close proximity thus ensuring privacy; and

Whereas, A contact tracing app using the Apple/Google API does not track GPS location and instead uses a decentralized database and decentralized privacy-preserving proximity tracing (DP-3T)-based technology to keep users anonymous; and

Whereas, The states currently using the Apple/Google API in their contact tracing apps allow the user to turn off exposure notification at any time to protect user autonomy; and

Whereas, The Apple/Google API technology aligns with the preferred Centers for Disease Control and Prevention preliminary criteria for digital contact tracing tools; and
Whereas, As of January 2021, Texas remains one of 32 states without a contact tracing app available for
download, and the remaining 18 states including California, New York, Colorado, and Alabama all have
created a contact tracing app using the Apple/Google API; and

Whereas, It is the responsibility of each state’s health department to decide whether or not to create a
statewide contact tracing app; and

Whereas, Both American Medical Association policies H-20.915 and H-440.931, and Texas Medical
Association Policy 15.001 support state adoption of contact tracing and notification programs for sexually
transmitted diseases such as HIV and syphilis; therefore be it

RESOLVED. That our Texas Medical Association support the development of a statewide contact tracing
app made by the Texas Department of State Health Service (DSHS) in accordance with Centers for
Disease Control and Prevention preliminary criteria for digital contact tracing in addition to conventional
tracing methods; and be it further

RESOLVED, That our TMA support efforts to promote and make widely known the use of a contact
tracing app made by DSHS; and be it further

RESOLVED, That our TMA support the efforts to educate the general public that a contact tracing app
made by DSHS ensures patient safety and privacy to encourage public buy-in.

Related TMA Policy:
118.003 Health Information Technology
15.001 HIV and Syphilis Contact Tracing

Related AMA Policy:
H-20.915 HIV/AIDS Reporting, Confidentiality, and Notification
H-440.931 Update on Tuberculosis

References:
1. Keeling MJ, Hollingsworth TD, Read JM. Efficacy of contact tracing for the containment of the 2019
doi:10.1136/jech-2020-214051.
2. Root J. As COVID Cases exploded, workers on Texas’ $295 million contact tracing deal did little to
3. Gonzalez V. Contact tracing – it’s still happening, but don’t expect to hear from someone. The
4. Playoff E. As coronavirus cases surged, Texas’ contact tracing workforce shrunk. The Texas Tribune.
5. Sinha P, Paterson AE. Contact tracing: Can ‘Big tech’ come to the rescue, and if so, at what cost?.
6. Simmons-Duffin S. States Nearly Doubled Plans For Contact Tracers Since NPR Surveyed Them 10
7. Almagor, J., Picascia, S. Exploring the effectiveness of a COVID-19 contact tracing app using an


Subject: Mental Health Education in Schools

Introduced by: Kerr-Bandera Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, suicide is the second leading cause of death in young people aged 10-24 in the U.S; and

Whereas, suicide is the second leading cause of death for young people aged 10-24 in Texas, and similarly, 19% of all Texas high school students seriously considered suicide during the past year and 10% made a suicide attempt during the past year; and

Whereas, the onset of more serious and chronic mental illnesses typically occurs in childhood and adolescence, during a time when students spend most of their time in a classroom; and

Whereas, as of 2009, Texas no longer mandates that a health class be required for high school graduation; therefore be it

RESOLVED, That the Texas Medical Association urge state legislators to make mental health education and awareness part of mandated school curriculum in Texas from elementary through high school.

Related TMA Policy:
55.019 Comprehensive School Health Education

Related AMA Policy:
D-345.994 Increasing Detection of Mental Illness and Encouraging Education

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 353
2021

Subject: Recognizing the Effect of Climate Change on Public Health (Tabled Res 323 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The fifth assessment report of the Intergovernmental Panel on Climate Change concluded that human influence on the climate system is clear” and “recent climate changes have had widespread impacts on human and natural systems”; and

Whereas, The World Health Organization estimates that climate change could cause approximately 250,000 additional deaths per year from 2030 to 2050 due to malnutrition, malaria, diarrhea, and heat stress; and

Whereas, A meta-analysis of global systemic risk associated with climate change found that 1,546 papers between 1989 and 2013 indicated a direct link between environmental change and negative health risks; and,

Whereas, According to the National Institute of Environmental Health Sciences, the most common noncommunicable chronic diseases – heart disease, stroke, cancer, diabetes, and respiratory diseases, which account for 60% of the 58 million global annual deaths – are significantly exacerbated by climate change, due to increased average temperatures, air pollution, and chemical contaminants, and increased ultraviolet radiation exposure in urban communities; and

Whereas, A meta-analysis of 18 mortality publications representing 3,933,398 elderly mortality cases from 1980 to 2010 found that a one degree Celsius temperature rise increased cardiovascular mortality by 3.44%, respiratory mortality by 3.60%, and cerebrovascular mortality by 1.40%; and

Whereas, The American Medical Association “[s]upports the findings of the Intergovernmental Panel on Climate Change’s fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant” and recognizes that “these climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor” (Global Climate Change and Human Health H-135.938); and

Whereas, Human-induced climate change likely increased the chances of the observed precipitation accumulations during Hurricane Harvey in the most affected areas of Houston by a factor of at least 3.59; and

Whereas, Climate change exacerbated the effects of the record-setting 2011 Texas drought, causing $5.2 billion dollars in agricultural losses, and similar bouts of extreme drought and heatwaves are predicted to increase in Texas; and
Whereas, The Clear Creek watershed in Houston will continue to experience larger periods of dry spells
alternating with increasingly severe periods of concentrated precipitation, increasing the risks of droughts
and flooding; and

Whereas, Parts of Texas have increased in average temperature more than 1.5 degrees Fahrenheit
between 1986 and 2016, and temperatures are projected to rise another one to six degrees Fahrenheit by
2100; therefore be it

RESOLVED, That the Texas Medical Association concur with the scientific consensus that Earth is
undergoing adverse global climate change with anthropologic contributions, and acknowledge that
climate change will increasingly affect public health, with disproportionate impacts on vulnerable
populations such as children, the elderly, and people of low socioeconomic status.

Related TMA Policy:
265.018 Evidence-Based Medicine and Practice

Related AMA Policy:
Global Climate Change and Human Health H-135.938

References:
1. Intergovernmental Panel on Climate Change. AR5 synthesis report: Climate change 2014.
   federal efforts to reduce fiscal exposure, GAO-17-720. 2017.
5. Butler CD. Climate change, health and existential risks to civilization: A comprehensive review
   Needs on the Human Health Effects of Climate Change. Environmental Health Perspectives/National
   Institute of Environmental Health Sciences. April 22, 2010.
   the elderly: A systematic review and meta-analysis of epidemiological evidence. EBioMedicine.
   2016;6, 258-268.
9. Wehner MF, et al. Attributable human-induced changes in the likelihood and magnitude of the
   observed extreme precipitation during Hurricane Harvey. Geophysical Research Letters. 2017
   Dec;44(24).
    10.1175/JCLI-D-12-00270.1.
    Anthropocene. 2019 Mar;25.
    Fourth National Climate Assessment, Volume I (Wuebbles DJ, Fahey DW, Hibbard KA, Dokken DJ, 
    Stewart BC, Maycock TK [eds.]). U.S. Global Change Research Program, Washington, DC, USA, 
Subject: Addressing Race in Medicine

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The history of medicine involves injustices against racial minorities by the medical community such as the unconsented use of HeLa cells, racial segregation in the Red Cross blood donor program, and the performance of gynecological operations without anesthesia by J. Marion Sims on Black enslaved people he purchased; and

Whereas, The Tuskegee syphilis study denied syphilis treatment to a group of Black men from 1932 to 1972, leading to significantly lower utilization of medical services by older Black men who lived near study subjects in the immediate years after study conditions were revealed; and

Whereas, 59% of Latina women and 23% of Latino men were at greater risk of forced sterilization in California between 1920 and 1945 under U.S. sterilization laws written to prevent reproduction of “unfit” individuals; and

Whereas, Systemic racism has been integrated into the current health care system, such as the inclusion of race in the calculation of estimated glomerular filtration rates, which results in underestimating chronic kidney disease in Black patients; the underrepresentation of pathologies on dark skin in medical textbooks; an almost tripling of the frequency of occult hypoxia undetected by pulse oximetry in Black patients compared with white patients; and conglomeration of Asian ethnic subgroups, which prevents proper evaluation of health risks per population; and

Whereas, Undocumented immigrants have less access to health care because of policies preventing qualification for the Affordable Care Act, Medicaid, or Medicare; and

Whereas, Increased anti-immigration rhetoric negatively impacts the health of undocumented immigrants, who may avoid seeking health care out of fear of discrimination, detention, and/or deportation; and

Whereas, The national cutoff for obesity of body mass index (BMI) $\geq 30$ kg/m$^2$ is an inaccurate representation for Asians, who demonstrated that lower BMI values (~23) tend to have a higher risk of diabetes and hypertension compared with other race/ethnic groups; and

Whereas, Black people, American Indians and Alaska Natives, and Native Hawaiians/Pacific Islanders receive worse care than white people in 40% of quality measures set by the Agency for Healthcare Research and Quality; and

Whereas, Foreign-born Latinx people comprise 48% of the Latinx population in the U.S., with 20% reporting to have experienced discrimination on the basis of ethnic, cultural, and language differences; and

Whereas, Black people, East Asians, and South Asians perceiving discrimination in a health care setting rate their health status as poor and are less likely to use health services; and
Whereas, The Indian Health Service provides care to 2.2 million Native Americans across the country and has been underfunded, limiting health services offered to Native Americans; and

Whereas, 23% of Native Americans reported facing discrimination in clinical encounters, and 15% avoided seeking care for themselves and family members because of anticipated discrimination; and

Whereas, Native Americans have an increased rate of mortality from preventable illnesses such as chronic liver disease and cirrhosis, diabetes, and chronic lower respiratory diseases and face a life expectancy of 20 years less than the national average in some states; and

Whereas, Disparities are seen in COVID-19 cases among minorities, such as non-Hispanic American Indian and Alaska Natives comprising 1.3% of COVID-19 cases despite comprising only 0.7% of the U.S. population; and

Whereas, Only 1,686 out of 29,675 people detained in U.S. Immigration and Customs Enforcement detention centers had been tested for COVID-19 by May 11, 2020, despite the spread of COVID-19 among detainees; and

Whereas, Physicians are not trained in competent cultural humility and history and continue to risk increased incidents of perpetuating inequitable care due to implicit bias; and

Whereas, Physicians' implicit biases prevent adequate care and amount to worse health outcomes such as Black children receiving fewer antibiotics than their white counterparts, a lower rating for pain assessments in Black patients, and low cancer screening rates in Asian Americans despite cancer being a leading cause of death in this racial group; and

Whereas, The Texas Medical Board does not require physicians to have further education on past and present bias linked to race; and

Whereas, Racial and ethnic representation in clinicians has proven to mitigate inequitable health outcomes for underrepresented racial and ethnic minority communities; and

Whereas, There is a statistically significant change in implicit bias and behavior based on the medical school experiences of a student within a formal curriculum that addresses targeted care for minorities and cultural competency and an informal curriculum that contains interracial contact, behavior of faculty, and the overall cultural climate; and

Whereas, Current training about racism and implicit bias in medical education allows students and clinicians to learn about their effects on health disparities, leading to reduced racism in patient care; and

Whereas, The American Medical Association released a statement on Jan. 6, 2021, in support of “the Biden administration’s comprehensive efforts to dismantle systemic racism and advance equity for all, particularly for historically marginalized communities who have long been underserved and overlooked in our country”; therefore be it

RESOLVED, That our Texas Medical Association support the development of curriculum in Texas medical schools that addresses the history of race in medicine and its present-day effects for minority groups including but not limited to Black, Latinx, Indigenous (American Indians and Alaska Natives, native Hawaiians/Pacific Islanders), and Asian populations; and be it further
RESOLVED, That TMA encourage all members to participate in a continuing medical education program that addresses the history of race in medicine and its present-day effects for minority groups including but not limited to Black, Latinx, Indigenous (American Indians and Alaska Natives, native Hawaiians/Pacific Islanders), and Asian populations; and be it further

RESOLVED, That TMA create a Committee for Minority Health and Issues to address health disparities among minorities in Texas.

Fiscal Note: $2,500/year

Relevant TMA Policy:
- 185.009 Promotion of Medicine and Health Careers to Underrepresented Minorities
- 200.020 Medical Education Curriculum
- 200.049 Advocacy Education in Medical School Curriculum

Relevant AMA Policy:
- Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984

References:


Subject: Support of Medical Student Health and Wellness

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Research indicates 27% of medical students experience depression, and 11% experience suicidal ideation at some point in their training; and

Whereas, Studies demonstrate that medical students suffer from psychological stress at significantly higher rates than their age-matched peers in the general population; and

Whereas, Approximately half of all medical students are estimated to experience burnout at some point during their medical school training; and

Whereas, Medical students are less likely to seek mental health support than the general population because of concerns about stigmatization, lack of time, and the fear of a lack of confidentiality; and

Whereas, Prolonged burnout can hinder the training of medical students, which can lead to harmful life-threatening consequences for students and their future patients; and

Whereas, Discussion regarding burnout has previously focused on physicians and residents, often excluding the effects of burnout on the medical student population; and

Whereas, Separate investigations conducted at the John A. Burns School of Medicine at the University of Hawai‘i at Mānoa and the School of Clinical Medicine, University of Cambridge showed the promotion of individualized counseling services successfully reduced suicidal ideation and emotional distress in medical students; and

Whereas, American Medical Association Policy H-345.973 supports “availability of timely, confidential, accessible, and affordable medical and mental health services for medical students,” TMA currently lacks similar policy; and

Whereas, Texas Medical Association Policy 105.010 supports the health and wellness of physicians, and has no similar policy regarding medical students; therefore be it

RESOLVED, That Texas Medical Association encourage the development of evidence-based methods to detect, treat, and prevent mental health issues in medical students; and be it further

RESOLVED, That TMA promote awareness of the prevalence of mental illness among medical students and therapeutic resources available to treat these illnesses; and be it further

RESOLVED, That TMA encourage Texas medical schools to recognize common barriers that deter medical students from seeking counseling services; and be it further
RESOLVED, That TMA encourage the development of peer support group sessions within medical schools to promote open discussion of mental health and build support among students.

Related TMA Policy:
- 100.022 Emergency Psychiatric Services
- 105.010 Physician Health and Wellness
- 145.019 Mental Health Equitable Treatment and Parity
- 215.019 Public Mental Health Care Funding
- 260.037 Essential Public Health Services

Related AMA Policy:
- D-405.990 Educating Physicians About Physician Health Programs and Advocating for Standards
- H-405.961 Physician Health Programs
- H-345.973 Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians
- H-405.959 Physicians and Physicians-in-Training as Examples for Their Patients to Promote Wellness and Healthy Lifestyles

References:
2. AMA Principles of Medical Ethics: I, II, IV


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 356
2021

Subject: Support Statewide Planning and Communication for a Vaccine Plan During a Pandemic

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, An emergency vaccination plan was created by the Center of Disease and Detection and the Advisory Committee on Immunization Practices (ACIPs) in 2020 due to the COVID-19 pandemic and implemented in Texas; and

Whereas, Texas’s attempt to implement the ACIP’s COVID-19 vaccine distribution plan was disorganized and confusing, secondary to poor communication from state officials, technical errors, and logistical delays; and

Whereas, Specifically, throughout the vaccine rollout there have been significant gaps in communication between providers, residents, and Texas state officials regarding COVID-19 vaccine availability and eligibility; and

Whereas, A major technical error occurred when the Texas Division of Emergency Management and the Texas Department of State Health Services displayed different maps of vaccine distribution; and

Whereas, The system used to track vaccinations, ImmTrac2, experienced significant lag in uploading data causing confusion in vaccine availability; and

Whereas, Vaccine hesitancy was listed by the World Health Organization as a top 10 threat to global health in 2019 and misinformation provided throughout the COVID-19 vaccination rollout could further increase this hesitancy in Texas residents; and

Whereas, Vaccine hesitancy and mistrust of the COVID-19 vaccination by the public is exhibited in a November 2020 survey where 39% of Americans reported they do not plan on getting the COVID-19 vaccine; and

Whereas, During this current vaccine rollout there was significant variability in states’ plans for COVID-19 vaccine distribution, with only 23 states having strategies to target minorities and only 18 states having strategies to combat vaccine misinformation, Texas not being one of these; and

Whereas, Texas was one of the first states to break from the CDC’s recommended vaccination plan; and

Whereas, Texas moved towards vaccinating the state’s elderly population, the third highest amongst all states, and the digital race to sign up was a struggle for many seniors; and

Whereas, There are more than 4 million people in phase 1B in Texas alone, and all these individuals cannot receive vaccinations at once, therefore lawmakers have suggested creating subgroups in the future to prevent overwhelming the system and confusing residents, exemplifying Texas’s need for a plan unique to its population; and
Whereas, Texas’s unique population also includes a large amount of small, rural hospitals with less than 975 employees, and many of these small rural hospitals were excluded from the first rollout of COVID-19 vaccines although they employed frontline health care workers battling COVID-19; and

Whereas, TMA already supports in 135.015 the efficient distribution system for delivering vaccines during a shortage in cooperation with the Texas Department of State Health Services, local health departments, and county medical societies; and

Whereas, A strong and reliable vaccine rollout plan, as well as a public education campaign with clear user-friendly information, is necessary to combat mistrust around the COVID-19 vaccine, ensure vaccines are not wasted, and be prepared for future pandemic vaccines; therefore be it

RESOLVED, That TMA support modifying the state’s current emergency vaccination plan to better meet Texas’s population needs, with specific attention given to Texas’s large population, Texas’s elderly population, minority population, and rural populations, and allow for improved communication to citizens in the event of an emergency vaccination rollout; and be it further

RESOLVED, That TMA study ways to improve and simplify vaccine rollout in the future to combat vaccine hesitancy; and be it further

RESOLVED, That TMA support the use of user-friendly, easily accessible resources for information about new vaccines and vaccine roll-out plans in the state of Texas, to decrease vaccine hesitancy and aid in distribution.

Relevant TMA Policy:

135.005 National Vaccine Plan
135.015 Vaccine and Antimicrobials Distribution During a Shortage

Relevant AMA Policy:

Secure National Vaccine Policy H-440.882
Distribution and Administration of Vaccines H-440.877
Influenza Vaccine Availability and Distribution H-440.851
Protecting Patients and the Public Through Physician, Health Care Worker, and Caregiver Immunization H-440.831
Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875

References:


