REPORTS OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

The following reports were presented by Alexander Ding, MD, MPH, MBA, Chair:

1. COUNCIL ON SCIENCE AND PUBLIC HEALTH SUNSET REVIEW OF 2011 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association policies to ensure that our AMA's policy database is current, coherent, and relevant. This policy reads as follows, laying out the parameters for review and specifying the needed procedures:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Council on Science and Public Health recommends that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

APPENDIX - Recommended Actions

Policy Number	Title	Text	Recommendation
D-100.971	Physician Awareness and Education About Pharmaceutical and Biological Risk Evaluation and Mitigation	Our AMA will: (1) work with the pharmaceutical and biological industries to increase physician awareness of Risk Evaluation and Mitigation Strategies (REMS) as a means to improve patient safety; and (2) work with the e-prescribing and point of care resource industries to increase physician awareness of REMS as a means to improve patient safety by	Retain; still relevant.

		including current Risk Evaluation and Mitigation Strategy information in their products. (Res. 521, A-12)	
D-115.990	Prescription Container Labeling	1. Our AMA will work with relevant organizations to improve prescription labeling for visually or otherwise impaired patients and to increase awareness of available resources. 2. Our AMA will encourage state Boards of Pharmacy to adopt the newly revised standards contained in the United States Pharmacopeia general chapter on prescription container labeling, which offers specific guidance on how prescription labels should be organized in a patient-centered manner. (Res. 914, I-08; Appended: Res. 904, I-12)	Retain as amended. USP standards were last updated in 2020.
D-120.950	Use of Atypical Antipsychotics in Pediatric Patients	Our AMA will: (1) urge the National Institute of Mental Health to assist in developing guidance for physicians on the use of atypical antipsychotic drugs in pediatric patients; and (2) encourage and support ongoing federally funded research, with a focus on long term efficacy and safety studies, on the use of antipsychotic medication in the pediatric population. (CSAPH Rep. 1, I-12)	Retain, still relevant.
D-130.974	Emergency Preparedness	Our AMA (1) encourages state and local public health jurisdictions to develop and periodically update, with public and professional input, a comprehensive Public Health Disaster Plan specific to their locations. The plan should: (a) provide for special populations such as children, the indigent, and the disabled; (b) provide for anticipated public health needs of the affected and stranded communities including disparate, hospitalized and institutionalized populations; (c) provide for appropriate coordination and assignment of volunteer physicians; and (d) be deposited in a timely manner with the Federal Emergency Management Agency, the Public Health Service, the Department of Health and Human Services, the Department of Homeland Security and other appropriate federal agencies; and (2) encourages the Federation of State Medical Boards to implement a clearinghouse for volunteer physicians (MDs and DOs) that would (a) validate licensure in any state, district or territory to provide medical services in another distressed jurisdiction where a federal emergency has been declared; and (b) support national legislation that gives qualified physician volunteers (MDs and DOs), automatic medical liability immunity in the event of a declared national disaster or federal emergency. (Sub. Res. 803, I-05; Reaffirmation A-06; Reaffirmed: BOT Rep. 2, A-07; Reaffirmed in lieu of Res. 938, I-11; Modified: BOT action in response to referred for decision Res. 415, A-12)	Retain; as amended to reference the Departments of Homeland Security and Health and Human Services and other appropriate federal agencies rather than specifying all relevant agencies within these two departments.
D-135.977	Synthetic Gasification	Our AMA supports will encourage the study of the health effects of clean coal technologies including synthetic gasification plants. (Res. 514, A-12)	Retain as amended and change to H-policy.
D-425.992	Recommendations by the USPSTF	Our AMA will express concern regarding recent recommendations by the United States Preventive Services Task Force (USPSTF) on screening mammography and prostate specific antigen (PSA) screening and the effects these USPSTF recommendations have on limiting access to preventive care for Americans and will encourage the USPSTF to implement procedures that allow for meaningful input on recommendation development from specialists and stakeholders in the topic area under study. (Res. 517, A-12)	Rescind, accomplished. These screenings are also addressed by Policy H-525.993,“Screening Mammography,” and Policy H-425.980, “Screening and Early Detection of Prostate Cancer.”

			Existing policy also addresses physician engagement in expert panels (See. H-410.955 and H-410.967 included below).
D-440.938	Triclosan Antimicrobials	Our AMA will encourage the Food and Drug Administration to finalize the triclosan antimicrobial monograph first drafted in 1978 and updated in 1994 which found evidence for the safety and effectiveness of only alcohol and iodine-based topical products in health care use and will encourage the education of members on the issue of the importance of proper hand hygiene and the preferential use of plain soap and water or alcohol-based hand sanitizers in health care settings, consistent with the recommendations of the Centers for Disease Control and Prevention. (Res. 513, A-12)	Rescind. The FDA has issued a final rule (82 FR 60474) and established in 21 CFR 310 that Triclosan among other ingredients are not recognized as safe and effective,
D-440.999	Chemical Analysis Report of Public and Commercial Water	Our AMA: (1) requests the appropriate federal agency to require analysis and appropriate labeling of the chemical content, including fluoride, of commercially bottled water, as well as of the water supplies of cities or towns; (2) urges the FDA to require that annual water quality reports from bottled water manufacturers be publicly accessible in a readily available format; and (3) urges the FDA to evaluate bottled water for changes in quality after typical storage conditions. (Res. 427, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 3, A-12)	Retain; still relevant.
D-470.993	Government to Support Community Exercise Venues	Our AMA will encourages: (1) towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities; and (2) governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities. (Res. 423, A-04; Reaffirmed in lieu of Res. 434, A-12)	Retain as amended and change to an H policy.
D-480.977	Medical Device "Use Before Dates"	Our AMA will encourage the US Food and Drug Administration to clearly define and interpret the definition and meaning of the "use before date" for medical devices. (Res. 508, A-12)	Retain, still relevant.
D-95.978	Public Service Announcements to Educate Children and Adults to Never to Use Medications Prescribed to Other Individuals	Our AMA will encourages interested stakeholders, federal agencies and pharmaceutical companies to develop public service announcements for television and other media to educate children and adults about the dangers of taking medications that are prescribed for others. (Res. 910, I-12)	Retain as amended and change to an H policy.
H-100.961	The Evolving Culture of Drug Safety in the United States: Risk Evaluation and Mitigation Strategies (REMS)	Our AMA urges that: (1) The Food and Drug Administration (FDA) issue a final industry guidance on Risk Evaluation and Mitigation Strategies (REMS) with provisions that: (a) require sponsors to consult with impacted physician groups and other key stakeholders early in the process when developing REMS with elements to assure safe use (ETASU); (b) establish a process to allow for physician feedback regarding emerging issues with REMS requirements; (c) clearly specify that sponsors must assess the impact of ETASU on patient access and clinical practice, particularly in underserved areas or for patients with serious and life threatening conditions, and to make such assessments publicly available; and (d) conduct a long-term assessment of the prescribing patterns of drugs with REMS requirements. (2) The FDA ensure appropriate Advisory Committee review of proposed REMS with ETASU before they are finalized as	Retain as amended to delete duplicate language.

		part of the premarket review of New Drug Applications, and that the Drug Safety and Risk Management Advisory Committee fulfills this obligation for drugs that are already on the market and subject to REMS because of new safety information. (3) To the extent practicable, a process is established whereby the FDA and sponsors work toward standardizing procedures for certification and enrollment in REMS programs, and the common definitions and procedures for centralizing and standardizing REMS that rely on ETASU are developed. (4) REMS-related documents intended for patients (e.g., Medication Guides, acknowledgment/consent forms) be tested for comprehension and be provided at the appropriate patient literacy level in a culturally competent manner. (5) The Food and Drug Administration (FDA) issue a final industry guidance on Risk Evaluation and Mitigation Strategies (REMS) with provisions that: (a) urge sponsors to consult with impacted physician groups and other key stakeholders early in the process when developing REMS with elements to assure safe use (ETASU); (b) establish a process to allow for physician feedback regarding emerging issues with REMS requirements; and (c) recommend that sponsors assess the impact of ETASU on patient access and clinical practice, particularly in underserved areas or for patients with serious and life threatening conditions, and to make such assessments publicly available. (6) The FDA, in concert with the pharmaceutical industry, evaluate the evidence for the overall effectiveness of REMS with ETASU in promoting the safe use of medications and appropriate prescribing behavior. (7) The FDA ensure appropriate Advisory Committee review of proposed REMS with ETASU before they are finalized as part of the premarket review of New Drug Applications, and that the Drug Safety and Risk Management Advisory Committee fulfills this obligation for drugs that are already on the market and subject to REMS because of new safety information. (8) To the extent practicable, a process is established whereby the FDA and sponsors work toward standardizing procedures for certification and enrollment in REMS programs, and the common definitions and procedures for centralizing and standardizing REMS that rely on ETASU are developed. (9) REMS-related documents intended for patients (e.g., Medication Guides, acknowledgment/consent forms) be tested for comprehension and be provided at the appropriate patient literacy level in a culturally competent manner. (107) The FDA solicit input from the physician community before establishing any REMS programs that require prescriber training in order to ensure that such training is necessary and meaningful, requirements are streamlined and administrative burdens are reduced. (CSAPH Rep. 8, A-10; Reaffirmed: Res. 917, I-10; Appended: CSAPH Rep. 3, I-12)	
H-120.950	Change DEA Procedures in Partial Filling of Schedule II Prescriptions	Our AMA supports changes to requests that the federal Drug Enforcement Administration's change its partial filling of Schedule II Prescription regulation (21 CFR 1306.13) so that patients can acquire the balance of a prescription if, for whatever reason, only a portion of the supply was dispensed when the prescription was presented to a licensed pharmacy. (Res. 505, A-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain in part as amended. The Comprehensive Addiction and Recovery Act of 2016 created new partial dispensing exceptions which were incorporated into the

			DEA pharmacist's manual in 2020.
H-120.973	DEA, Diagnosis and ICD-910-CM Codes on Prescriptions	Our AMA, in order to protect patient confidentiality and to minimize administrative burdens on physicians, opposes requirements by pharmacies, prescription services, and insurance plans to include such information as ICD-910-CM codes and diagnoses on prescriptions. (Sub. Res. 518, A-93; Reaffirmation A-97; Reaffirmed by Sub. Res. 205, A-98; Reaffirmed: Res. 523, A-00; Amended: Res. 527, A-02; Modified: CSAPH Rep. 1, A-12)	Retain as amended with change in title.
H-135.932	Light Pollution: Adverse Health Effects of Nighttime Lighting	Our AMA: 1. Supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency. 2. Recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment. 3. Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night. 4. That work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place. (CSAPH Rep. 4, A-12)	Retain, still relevant.
H-135.937	Advocating and Support for Light Pollution Control Efforts and Glare Reduction for Both Public Safety and Energy Savings	Our AMA: (1) will advocate that all future outdoor lighting be of energy efficient designs to reduce waste of energy and production of greenhouse gasses that result from this wasted energy use; (2) supports light pollution reduction efforts and glare reduction efforts at both the national and state levels; and (3) supports efforts to ensure all future streetlights be of a fully shielded design or similar non-glare design to improve the safety of our roadways for all, but especially vision impaired and older drivers. (Res. 516, A-09; Reaffirmed: CSAPH Rep. 4, A-12)	Retain, as amended still relevant.
H-135.959	Eliminating Lead, Mercury and Benzene from Common Household Products	Our AMA: (1) supports the development of standards to achieve non-hazardous levels of exposure to lead, mercury, or benzene arising from common household or workplace products; (2) encourages efforts to minimize or eliminate mercury use in hospitals and other health care facilities; and (3) will work in coalitions with appropriate federal agencies and health care organizations to educate physicians and other health care professionals about suitable alternatives to the use of mercury and mercury-containing devices and the appropriate disposal of mercury and mercury-containing devices; (4) encourages efforts to minimize or eliminate lead in all commercial and household products. (Sub. Res. 418, I-92; Appended: Sub. Res. 410, A-00; Reaffirmation I-00; Reaffirmed A-03; Modified: CSAPH Rep. 7, A-10; Reaffirmed in lieu of Res. 522, A-12)	Retain; still relevant.
H-140.855	Gene Patents and Accessibility of Gene Testing	Our AMA: (1) opposes patents on naturally-occurring human DNA or RNA sequences; (2) supports legislation requiring that existing gene patents be broadly licensed so as not to limit access through exclusivity terms, excessive royalties or other unreasonable terms; and (3) supports legislation that would exempt from claims of infringement those who use patented genes for medical diagnosis and research. (Res. 526, A-10; Modified in lieu of Res. 504, A-12)	Retain; still relevant.

H-150.935	Encouraging Healthy Eating Behaviors in Children Through Corporate Responsibility	Our AMA: 1) supports and encourages corporate social responsibility in the use of marketing incentives that promote healthy childhood behaviors, including the consumption of healthy food in accordance with federal guidelines and recommendations; and 2) encourages fast food restaurants to establish competitive pricing between less healthy and more healthy food choices in children's meals. (Sub. Res. 402, A-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 435, A-12)	Retain; still relevant.
H-170.961	Prevention of Obesity Through Instruction in Public Schools	Our AMA will urge appropriate agencies to support legislation that would require meaningful yearly instruction in nutrition, including instruction in the causes, consequences, and prevention of obesity, in grades 1 through 12 in public schools and will encourage physicians to volunteer their time to assist with such an effort. (Res. 426, A-12)	Retain; still relevant.
H-170.999	Health Instruction and Physical Education in Schools	The AMA reaffirms its long-standing and fundamental belief that health education should be an integral and basic part of school and college curriculums, and encourages state and local medical societies to work with the appropriate health education officers and agencies in their communities to achieve this end. (BOT Res., A-60; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-07; Reaffirmed: BOT Rep. 21, A-12)	Retain; still relevant
H-245.968	Guidelines on Neonatal Resuscitation	Our AMA will support programs designed to educate health care professionals who treat premature infants, as well as parents and caregivers of premature infants, on evidence-based guidelines on neonatal resuscitation, especially with regard to premature infants born at the cusp of viability. (Sub. Res. 520, A-12)	Retain; still relevant.
H-250.988	Low Cost Drugs to Poor Economically Disadvantaged Countries During Times of Pandemic Health Crises	Our AMA: (1) encourages pharmaceutical companies to provide low cost medications to countries during times of pandemic health crises; and (2) shall work with the World Health Organization (WHO), UNAID, and similar organizations that provide comprehensive assistance, including health care, to poor economically disadvantaged countries in an effort to improve public health and national stability. (Res. 402, A-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain as amended with change in title. The term "economically disadvantaged" is preferred over "poor."
H-410.955	Physician Representation on Expert Panels	Our AMA encourages government panels and task forces dealing with specific disease entities to have representation by physicians with expertise in those diseases. (Res. 509, A-10; Reaffirmation A-12; Reaffirmed: Sub. Res. 517, A-12)	Retain; still relevant.
H-410.960	Quality Patient Care Measures	Our AMA encourages all physicians to be open to the development and broader utilization of evidence-based quality improvement guidelines (pathways, parameters) and indicators for measurement of quality practice. (Res. 811, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain; still relevant.
H-410.967	Guide to Clinical Preventive Services	The AMA: (1) recommends the USPSTF guidelines Guide to Clinical Preventive Services to clinicians and medical educators as one resource for guiding the delivery of clinical preventive services. USPSTF recommendations The Guide should not be construed as AMA policy on screening procedures and should not take the place of clinical judgment and the need for individualizing care with patients; physicians should weigh the utility of individual recommendations within the context of their scope of practice and the situation presented by each clinical encounter; (2) will continue to encourage the adoption of practice guidelines as they are developed based on the best scientific evidence and methodology available; and (3) will	Retain as amended with change in title. The terminology "Guide to Clinical Preventive Services" is no longer utilized.

		continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in preparation of practice guidelines. (CSA Rep. 1, A-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Sub. Res. 517, A-12)	
H-420.960	Effects of Work on Pregnancy	Our AMA: (1) supports the right of employees to work in safe workplaces that do not endanger their reproductive health or that of their unborn children; (2) supports workplace policies that minimize the risk of excessive exposure to toxins with known reproductive hazards irrespective of gender or age; (3) encourages physicians to consider the potential benefits and risks of occupational activities and exposures on an individual basis and work with patients and employers to define a healthy working environment for pregnant people women; (4) encourages employers to accommodate women's increased physical requirements of pregnant peopleduring pregnancy; recommended accommodations include varied work positions, adequate rest and meal breaks, access to regular hydration, and minimizing heavy lifting; and (5) acknowledges that future research done by interdisciplinary study groups composed of obstetricians/gynecologists, occupational medicine specialists, pediatricians, and representatives from industry can best identify adverse reproductive exposures and appropriate accommodations. (CSA Rep. 9, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-12)	Retain as amended to include gender-neutral language.
H-430.994	Prison-Based Treatment Programs for Drug Abuse	Our AMA: (1) encourages the increased application to the prison setting of the principles, precepts and processes derived from drug-free residential therapeutic community experience; and (2) urges state health departments or other appropriate agencies to take the lead in working with correction and substance abuse agencies for the expansion of such prison-based drug-free treatment programs. (Sub. Res. 124, I-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmation: I-12)	Rescind. Outdated policy. See Policy H-430.987, "Medications for Opioid Use Disorder in Correctional Facilities"
H-430.997	Standards of Care for Inmates of Correctional Facilities	Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism. (Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12)	Retain as amended to reflect clinically accurate language.
H-440.844	Expansion of National Diabetes Prevention Program	Our AMA: (1) supports evidence-based, physician-prescribed diabetes prevention programs, (2) supports the expansion of the NDPP to more CDC-certified sites across the country; and (3) will support coverage of the NDPP by Medicare and all private insurers. (Sub. Res. 911, I-12)	Retain; still relevant.
H-440.848	Reimbursement for Influenza Vaccine	Our AMA: (1) will work with third party payers, including the Centers for Medicare and Medicaid Services, to establish a fair reimbursement price for the flu vaccine; (2) encourage the manufacturers of influenza vaccine to publish the purchase price by June 1st each year; (3) shall seek federal legislation or regulatory relief, or otherwise work with the federal government to increase Medicare reimbursement levels for flu vaccination and other vaccinations. (CSAPH Rep. 5, I-12)	Retain; still relevant.

H-440.849	Adult Immunization	Our AMA (1) supports the development of a strong adult and adolescent immunization program in the United States; (2) encourages physicians and other health and medical workers (in practice and in training) to set positive examples by assuring that they are completely immunized; (3) urges physicians to advocate immunization with all adult patients to whom they provide care, to provide indicated vaccines to ambulatory as well as hospitalized patients, and to maintain complete immunization records, providing copies to patients as necessary; (4) encourages the National Adult and Influenza Vaccine Immunization Summit to examine mechanisms to ensure that patient immunizations get communicated to their personal physician; (5) promotes use of available public and professional educational materials to increase use of vaccines and toxoids by physicians and to increase requests for and acceptance of these antigens by adults for whom they are indicated; and (6) encourages third party payers to provide coverage for adult immunizations. (CSAPH Rep. 5, I-12)	Retain as amended to reflect the appropriate name of the Summit.
H-440.852	Smallpox: A Scientific Update	Our AMA will remain engaged with the CDC, the Advisory Committee on Immunization Practices (ACIP), and the Federation on smallpox vaccination and support a commitment to monitor the current status of smallpox and smallpox vaccination in the world and in the United States and develop appropriate recommendations as necessary. (CSA Rep. 2, I-02; BOT Action in response to referred for decision Recommendation 2 of CSA Rep. 2, I-02; Modified: CCB/CLRPD Rep. 4, A-12)	Retain; still relevant.
H-440.872	HPV Vaccine and Cervical Cancer Prevention Worldwide	1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs. 2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public. 3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination. (Res. 503, A-07; Appended: Res. 6, A-12)	Retain; still relevant.
H-440.889	Smallpox: A Scientific Update	Our AMA strongly supports the June 20, 2002, Advisory Committee on Immunization Practices (ACIP) recommendations on the use of vaccinia (smallpox) vaccine in light of the available science and data. (CSA Rep. 2, I-02; Reaffirmed: CSAPH Rep. 1, A-12)	Retain with amendments; ACIP recommendations have been updated.
H-440.921	Pneumococcal Vaccination	Our AMA encourages physicians to expand their use of pneumococcal vaccine per current Advisory Committee on Immunization Practices recommendations, for those at increased risk of serious pneumococcal infection and for all persons age 65 and over. (Res. 512, A-94; Reaffirmed: Res. 515. I-01; Reaffirmed: Res. 520, A-02; Modified: CSAPH Rep. 1, A-12)	Retain with amendment should ACIP recommendations evolve based on the evidence.

H-445.995	Responses to News Reports and Articles	Our AMA encourages the public relations committees of all county, state and national medical societies to initiate positive programs with the media and to make timely responses to misleading and inaccurate media releases giving the general public a more accurate and balanced perspective of the medical profession and medical issues. (Res. 10, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-07; Reaffirmed: Res. 601, A-12)	Retain; still relevant.
H-460.905	Clinical Application of Next Generation Genomic Sequencing	1. Our AMA recognizes the utility of next-generation sequencing (NGS)-based technologies as tools to assist in diagnosis, prognosis, and management, and acknowledges their potential to improve health outcomes. 2. Our AMA encourages the development of standards for appropriate clinical use of NGS-based technologies and best practices for laboratories performing such tests. 3. Our AMA will monitor research on and implementation of NGS-based technologies in clinical care, and will work to inform and educate physicians and physicians-in-training on the clinical uses of such technologies. 4. Our AMA will support regulatory policy that protects patient rights and confidentiality, and enables physicians to access and use diagnostic tools, such as NGS-based technologies, that they believe are clinically appropriate. 5. Our AMA will continue to enhance its process for development of CPT codes for evolving molecular diagnostic services, such as those that are based on NGS; serve as a convener of stakeholders; and maintain its transparent, independent, and evidence-based process. (CSAPH Rep. 4, I-12)	Retain; still relevant.
H-470.975	Mandatory Physical Education	The AMA continues its commitment to support state and local efforts to implement quality physical education programs for all students, including those with physical, developmental, or intellectual challenges or other special needs in grades kindergarten through twelve, including ungraded classes. (Sub. Res. 1, I-88; Reaffirmation and Sunset Report, I-98; Reaffirmation A-07; Modified: BOT Rep. 21, A-12)	Retain; still relevant.
H-470.989	Physical Fitness and Physical Education	Our AMA: (1) urges school boards, administrators and parents to provide physical education programs during elementary, junior high and senior high years; and (2) stresses that these programs be conducted by qualified personnel, be designed to teach health habits and physical skills, and be designed to instill a desire in the student for physical fitness that will carry over into adult life. (CSA Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmation I-98; Reaffirmation A-04; Reaffirmation A-07; Reaffirmed: BOT Rep. 21, A-12)	Retain; still relevant
H-470.990	Promotion of Exercise Within Medicine and Society	Our AMA supports (1) education of the profession on exercise, including instruction on the role of exercise prescription in medical practice in its continuing education courses and conferences, whenever feasible and appropriate; (2) medical student instruction on the prescription of exercise; (3) physical education instruction in the school system; and (4) education of the public on the benefits of exercise, through its public relations program. (Res. 56, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation I-98; Reaffirmation A-07; Reaffirmed: BOT Rep. 21, A-12)	Retain; still relevant

H-470.996	School and College Physical Education	Our AMA encourages effective instruction in physical education for all students in our schools and colleges. (BOT Rep. I, A-69; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation I-98; Reaffirmation A-07; Reaffirmed: BOT Rep. 21, A-12)	Retain; still relevant
H-480.958	Bioengineered (Genetically Engineered) Crops and Foods	(1) Our AMA recognizes the continuing validity of the three major conclusions contained in the 1987 National Academy of Sciences white paper "Introduction of Recombinant DNA-Engineered Organisms into the Environment." [The three major conclusions are: (a)There is no evidence that unique hazards exist either in the use of rDNA techniques or in the movement of genes between unrelated organisms; (b) The risks associated with the introduction of rDNA-engineered organisms are the same in kind as those associated with the introduction of unmodified organisms and organisms modified by other methods; (c) Assessment of the risk of introducing rDNA-engineered organisms into the environment should be based on the nature of the organism and the environment into which it is introduced, not on the method by which it was produced.) (2) That federal regulatory oversight of agricultural biotechnology should continue to be science-based and guided by the characteristics of the plant or animal, its intended use, and the environment into which it is to be introduced, not by the method used to produce it, in order to facilitate comprehensive, efficient regulatory review of new bioengineered crops and foods. (3) Our AMA believes that as of June 2012, there is no scientific justification for special labeling of bioengineered foods, as a class, and that voluntary labeling is without value unless it is accompanied by focused consumer education. (4) Our AMA supports mandatory pre-market systematic safety assessments of bioengineered foods and encourages: (a) development and validation of additional techniques for the detection and/or assessment of unintended effects; (b) continued use of methods to detect substantive changes in nutrient or toxicant levels in bioengineered foods as part of a substantial equivalence evaluation; (c) development and use of alternative transformation technologies to avoid utilization of antibiotic resistance markers that code for clinically relevant antibiotics, where feasible; and (d) that priority should be given to basic research in food allergenicity to support the development of improved methods for identifying potential allergens. The FDA is urged to remain alert to new data on the health consequences of bioengineered foods and update its regulatory policies accordingly. (5) Our AMA supports continued research into the potential consequences to the environment of bioengineered crops including the: (a) assessment of the impacts of pest-protected crops on nontarget organisms compared to impacts of standard agricultural methods, through rigorous field evaluations; (b) assessment of gene flow and its potential consequences including key factors that regulate weed populations; rates at which pest resistance genes from the crop would be likely to spread among weed and wild populations; and the impact of novel resistance traits on weed abundance; (c) implementation of resistance management practices and continued monitoring of their effectiveness; (d) development of monitoring programs to assess ecological impacts of pest-protected crops that may not be apparent from the results of field tests; and (e) assessment of the agricultural impact of bioengineered foods, including the impact on farmers.	Retain; still relevant with acknowledgment by the Council that an updated report to review more recent data is warranted.

		(6) Our AMA recognizes the many potential benefits offered by bioengineered crops and foods, does not support a moratorium on planting bioengineered crops, and encourages ongoing research developments in food biotechnology. (7) Our AMA urges government, industry, consumer advocacy groups, and the scientific and medical communities to educate the public and improve the availability of unbiased information and research activities on bioengineered foods. (CSA Rep. 10, I-00; Modified: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, A-12)	
H-480.964	Alternative Medicine	Policy of the AMA on alternative medicine is: (1) Well-designed, controlled research should be done to evaluate the efficacy of alternative therapies. (2) Physicians should routinely inquire about the use of alternative or unconventional therapy by their patients, and educate themselves and their patients about the state of scientific knowledge with regard to alternative therapy that may be used or contemplated. (3) Patients who choose alternative therapies should be educated as to the hazards that might result from postponing or stopping conventional medical treatment. (CSA Rep. 12, A-97; Reaffirmed: BOT Rep. 36, A-02; Modified: CSAPH Rep. 1, A-12)	Retain; still relevant.
H-485.998	Television Commercials Aimed at Children	Our AMA opposes TV advertising and programming aimed specifically at exploiting children, particularly those ads and programs that have an impact on the health and safety of children. (Res. 27, A-79; Reaffirmed: CLRPD Rep. B, I-89; Sub. Res. 220, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmation A-12)	Retain; still relevant.
H-495.974	Tax Incentives and Films Depicting Tobacco	Our AMA will urge that no tax incentives be given for any motion picture production that depicts any tobacco product or non-pharmaceutical nicotine delivery device or its use, associated paraphernalia, related trademarks or promotional material, unless the film depicts the tobacco use of historical persons or unambiguously portrays the dire health consequences of tobacco use. (Res. 417, A-12)	Retain; still relevant.
H-495.981	Light and Low-Tar Cigarettes	Our AMA concurs with the key scientific findings of National Cancer Institute Monograph 13, Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields of Tar and Nicotine: (a) Epidemiological and other scientific evidence, including patterns of mortality from smoking-caused diseases, does not indicate a benefit to public health from changes in cigarette design and manufacturing over the last 50 years. (b) For spontaneous brand switchers, there appears to be complete compensation for nicotine delivery, reflecting more intensive smoking of lower-yield cigarettes. (c) Cigarettes with low machine-measured yields by Federal Trade Commission (FTC) methods are designed to allow compensatory smoking behaviors that enable a smoker to derive a wide range of tar and nicotine yields from the same brand. (d) Widespread adoption of lower yield cigarettes in the United States has not prevented the sustained increase in lung cancer among older smokers. (e) Many smokers switch to lower yield cigarettes out of concern for their health, believing these cigarettes to be less risky or to be a step toward quitting; many smokers switch to these products as an alternative to quitting. (f) Advertising and promotion of low tar cigarettes were	Retain; still relevant.

		intended to reassure smokers who were worried about the health risks of smoking, were meant to prevent smokers from quitting based on those same concerns; such advertising was successful in getting smokers to use low-yield brands. (g) Existing disease risk data do not support making a recommendation that smokers switch cigarette brands. The recommendation that individuals who cannot stop smoking should switch to low yield cigarettes can cause harm if it misleads smokers to postpone serious attempts at cessation. (h) Measurements of tar and nicotine yields using the FTC method do not offer smokers meaningful information on the amount of tar and nicotine they will receive from a cigarette. Our AMA seeks legislation or regulation to prohibit cigarette manufacturers from using deceptive terms such as "light," "ultra-light," "mild," and "low-tar" to describe their products. (CSA Rep. 3, A-04; Reaffirmed in lieu of Res. 421, A-12)	
H-515.959	Reduction of Online Bullying	Our AMA urges social networking platforms to adopt Terms of Service that define and prohibit electronic aggression, which may include any type of harassment or bullying, including but not limited to that occurring through e-mail, chat room, instant messaging, website (including blogs) or text messaging. (Res. 401, A-12)	Retain; still relevant
H-525.984	Breast Implants	Our AMA: (1) supports that individuals women be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated. (CSA Rep. M, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 727, I-02; Modified: CSAPH Rep. 1, A-12)	Retain as amended; to include gender-neutral language.
H-55.974	Study of Cancer Incidence in 9/ll Responders	Our AMA will encourage further study of the association between post-September 11, 2001 World Trade Center attack exposure and cancer incidence. (Res. 501, A-12)	Retain; still relevant.
H-60.927	Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations	Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth. (Res. 402, A-12)	Retain; still relevant
H-60.943	Bullying Behaviors Among Children and Adolescents	Our AMA: (1) recognizes bullying as a complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents. Bullying is defined as a pattern of repeated aggression; with deliberate intent to harm or disturb a victim despite apparent victim distress; and a real or perceived imbalance of power (e.g., due to age, strength, size), with the more powerful child or group attacking a physically or psychologically vulnerable victim; (2) advocates for federal support of research: (a) for the development and effectiveness testing of programs to prevent or reduce bullying behaviors, which should include rigorous program evaluation to determine long-term outcomes; (b) for the development of effective clinical tools and protocols for the identification, treatment, and referral of children and adolescents at risk for and traumatized by bullying; (c) to further elucidate biological, familial, and environmental underpinnings of aggressive and violent	Retain; still relevant

		behaviors and the effects of such behaviors; and (d) to study the development of social and emotional competency and resiliency, and other factors that mitigate against violence and aggression in children and adolescents; (3) urges physicians to (a) be vigilant for signs and symptoms of bullying and other psychosocial trauma and distress in children and adolescents; (b) enhance their awareness of the social and mental health consequences of bullying and other aggressive behaviors; (c) screen for psychiatric comorbidities in at-risk patients; (d) counsel affected patients and their families on effective intervention programs and coping strategies; and (e) advocate for family, school, and community programs and services for victims and perpetrators of bullying and other forms of violence and aggression; (4) advocates for federal, state, and local resources to increase the capacity of schools to provide safe and effective educational programs by which students can learn to reduce and prevent violence. This includes: (a) programs to teach, as early as possible, respect and tolerance, sensitivity to diversity, and interpersonal problem-solving; (b) violence reduction curricula as part of education and training for teachers, administrators, school staff, and students; (c) age and developmentally appropriate educational materials about the effects of violence and aggression; (d) proactive steps and policies to eliminate bullying and other aggressive behaviors; and (e) parental involvement; (5) advocates for expanded funding of comprehensive school-based programs to provide assessment, consultation, and intervention services for bullies and victimized students, as well as provide assistance to school staff, parents, and others with the development of programs and strategies to reduce bullying and other aggressive behaviors; and (6) urges parents and other caretakers of children and adolescents to: (a) be actively involved in their child's school and community activities; (b) teach children how to interact socially, resolve conflicts, deal with frustration, and cope with anger and stress; and (c) build supportive home environments that demonstrate respect, tolerance, and caring and that do not tolerate bullying, harassment, intimidation, social isolation, and exclusion. (CSA Rep. 1, A-02; Reaffirmed: CSAPH Rep. 1, A-12)	
H-60.991	Providing Medical Services through School-Based Health Programs	(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators,	Retain; still relevant.

		parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children. (CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12)	
H-65.973	Health Care Disparities in Same-Sex Partner Households	Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households. (CSAPH Rep. 1, I-09; BOT Action in response to referred for decision Res. 918, I-09: Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11; Reaffirmed in lieu of Res. 209, A-12)	Retain; still relevant.
H-85.961	Accuracy, Importance, and Application of Data from the US Vital Statistics System	Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and infant, as this information is the basis for the health and medical information on birth certificates. (CSA Rep. 6, I-00; Reaffirmed: Sub. Res. 419, A-02; Modified: CSAPH Rep. 1, A-12)	Retain; still relevant.

2. TRANSFORMATION OF RURAL COMMUNITY PUBLIC HEALTH SYSTEMS

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policies H-465.994, H-478.980, and D-440.924

INTRODUCTION

Policy H-465.994, "Improving Rural Health," asks that our American Medical Association study efforts to optimize rural public health.

BACKGROUND

More than 65 million people living in the United States reside in rural jurisdictions.[1] Rural populations tend to be older, poorer, have less access to health care, have riskier health behaviors, and worse health outcomes than their urban counterparts.[2,3] Data from the Centers for Disease Control and Prevention (CDC) demonstrate that people living in rural areas are more likely to die from five leading causes of death (heart disease, cancer, unintentional injuries, chronic lower respiratory disease, and stroke) than their urban counterparts.[3] However, the challenges faced by rural areas are not uniform as they have their own unique cultural and geographic differences that benefit from leadership at the local level.

The Council's N-21 report, "Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems," is highly relevant to this report. That report identified eight major gaps or challenges in the U.S. public health infrastructure. While those challenges were not specific to rural public health, they are broadly applicable across the governmental public health enterprise. These include: (1) the lack of understanding and appreciation for public health; (2) the lack of consistent, sustainable public health funding; (3) legal authority and politicization of public health; (4) the governmental public health workforce; (5) the lack of data and surveillance and interoperability between health care and public health; (6) insufficient laboratory capacity; (7) the lack of collaboration between medicine and public health; and (8) the gaps in the public health infrastructure which contribute to the increasing inequities we see in health outcomes. This report recognizes that these challenges are applicable to rural public health, but this report seeks to build on those findings to examine the challenges and opportunities specific to rural public health.

Furthermore, issues related to rural health care have recently been studied by other AMA councils and will not be the focus of this report. Report 3 of the Council on Medical Education, "Rural Health Physician Workforce Disparities" was adopted as amended by the House of Delegates in November of 2021. The report recognized the need for a multifaceted approach to address the gap of rural health services and noted that the AMA continues to work to help identify ways to encourage and incentivize qualified physicians to practice in our nation's underserved areas, including strategies to increase rural students' exposure to careers in medicine to help expand rural physician pathways. Report 9 of the Council on Medical Services, "Addressing Payment and Delivery in Rural Hospitals" was adopted as amended by the House of Delegates in June of 2021. The report notes that addressing payment issues for rural hospitals will help give those hospitals the flexibility to offer more complex services. In turn, those services will boost financial viability, allow small rural hospitals to hire and retain subspecialists, and ultimately increase patient access to care. Policies resulting from these reports are noted below in the section on existing AMA policy.

There are numerous definitions of "rural." The definition of rural public health practice varies by study. Given the limited research available on rural public health, the Council was broadly inclusive of various definitions of rural, including the Census Bureau and the Office of Management and Budget definitions, in reviewing the literature for this report.

METHODS

English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2012 to January 2022 using the search terms: "rural public health," "rural community health," and "rural health." Additional articles were identified by manual review of the reference lists of pertinent publications. Websites

managed by federal agencies, applicable professional organizations, and foundations were also reviewed for relevant information.

DISCUSSION

Rural-Urban Disparities

Residents of rural communities tend to be sicker, poorer, and have worse health behaviors (e.g., higher alcohol and tobacco use, physical inactivity) than their urban peers. According to the Center for Rural Health Research, "the greatest challenge facing rural America is the confluence of four social vectors: poverty, educational underachievement, poor health behaviors, and lack of access to health care."[4] These four factors have produced "an intergenerational cycle" resulting in widening gaps between rural America and the rest of the country.[4]

While urban public health systems have enhanced their scope of activities and organizational networks since 2014, rural systems have lost capacity, suggesting system improvement initiatives have had uneven success.[5] While urban areas have seen significant improvements in some health indicators, rural areas continue to lag, widening rural-urban health disparities. For example, from 2007 to 2017, rural-urban mortality disparities increased for 5 of 7 major causes of death tracked by Healthy People 2020: coronary heart disease, cancer, diabetes, chronic obstructive pulmonary disease, and suicide.[6]

These disparities have also been evident during the COVID-19 pandemic. In September 2020, COVID-19 incidence (cases per 100,000 population) in rural counties surpassed that in urban counties.[7] When the CDC analyzed county-level vaccine administration data among adults aged 18 and older who received their first dose of either the Pfizer-BioNTech or Moderna COVID-19 vaccine, or a single dose of the Janssen COVID-19 vaccine from December 14, 2020–April 10, 2021. They found that adult COVID-19 vaccination coverage was lower in rural counties (38.9 percent) than in urban counties (45.7 percent) overall.[7] Though it is suggested that implementing approaches tailored to local community needs, partnering with local community-based organizations and faith leaders, and engaging with underserved populations directly and through partners has helped increase vaccination rates in some rural communities.[7]

In describing disparities between rural and urban communities, there is a focus on the lack of resources and resulting impact on health of those living in rural communities, but it is important to highlight that the lack of resources has stimulated creativity and often brings people together across sectors in rural communities to solve the problems facing their population.[8] Researchers working in rural communities describe "cross-sector engagement facilitated by strong social cohesion and a willingness to roll up one's sleeves to address challenges head on."[8] This "strong connectivity across sectors and actors" in rural areas, has resulted in organizations forming partnerships to address issues related to the economy, nutrition, health care, business, and education.[9] Research also suggests that rural communities are resilient, defined as "the ability to prepare and plan for, absorb, recover from or more successfully adapt to actual or potential adverse events." This resilience enables rural communities to respond to economic and social changes.[9] Rural communities are also described as having "pride in place, a shared history, and a shared culture.[8]

Access to Health Care

Access to health care in rural jurisdictions impacts the ability of the public health systems to focus on essential public health services and functions. Nearly 35 years ago, the Institute of Medicine's report on the "Future of Public Health" noted that the responsibility for providing medical care to individuals has drained vital resources and attention away from disease prevention and health promotion efforts that benefit the entire community.[10] While many health departments have moved away from providing clinical services, local health departments (LHDs) in rural areas are often left to fill the gaps in the absence of health care providers. If LHDs in these jurisdictions did stop providing clinical services, they would not be available for the general population. Rural LHDs play a critical role in meeting the needs of the residents by providing clinical preventive services, vaccinations, treatment, and maternal and child health services.[11] Rural LHDs also rely more on clinical services because they receive a higher proportion of revenue from clinical sources than their urban counterparts.[12]

HEALTH DEPARTMENT STRUCTURE AND FUNCTIONS

There are more than 2400 local health departments (LHDs) in the United States. It is estimated that about half of LHDs are rural and they differ from their urban and suburban counterparts.[1] Rural LHDs, similar to their urban counterparts, are often limited by budgets, staffing, and capacity constraints in providing public health services, thereby limiting their ability to respond to national public health and health care policy initiatives.[13] With less funding and fewer staff, rural LHDs are often not able to meet the needs of a sicker population over a larger geographical area.[14] It should be noted that some rural areas are not served by a LHD, but rather by a regional or state health department (e.g. Rhode Island).

Leadership and Workforce

Effective public health practice requires a well-prepared, multi-disciplinary workforce that is equipped to meet the needs of the community being served.[15] The Public Health Accreditation Board standards call for the development of a "sufficient number of qualified public health workers" and a competent workforce through assessment of staff competencies, individual training and professional development, and a supportive work environment. Building a strong public health workforce pipeline was also identified as a need in Public Health 3.0 with a focus on leadership and management skills in systems thinking and coalition building [16]

More than 80 percent of LHD full-time employees (FTEs) (112,000) are employed in departments serving urban areas. Only 18 percent of LHD FTEs (24,000) are employed by LHDs that serve rural populations.[17] Small, rural LHDs often have fewer staff than their urban counterparts.[1] Nurses are often the executive in jurisdictions with a population less than 50,000, while executives of jurisdictions with more than 250,000 are predominantly physicians.[18] Overall, small/rural health departments employ fewer FTEs than do large/urban departments, resulting in a narrower range of public health skills. Seventy-eight percent of LHD executives have no formal public health training, while executives of larger jurisdictions are more likely to have a public health degree.[18]

The other challenge facing the public health workforce more broadly is a significant number of governmental public health workers are planning to leave their position. Data form the Public Health Workforce Interests and Needs Survey found that more than one-fifth of LHD staff intended to leave their position in the next year for reasons other than retirement.[19] Salary, lack of opportunity for advancement, and workplace environment were the top three reasons for leaving.[19]

Funding Sources

The governmental public health system is inadequately funded. The CDC's core budget has been essentially flat, which directly impacts funding for state and local public health across the country.[20] Rural LHDs are more reliant on federal, state, and clinical revenues as compared to their urban counterparts.[1,17] The predictability and stability of public health financing poses a challenge for rural LHDs.[2] Operating on grant dollars can make it difficult to be responsive to community needs and to create new FTEs at the local level. Furthermore, transfers of governmental funding from federal and state levels to rural LHDs is less common as compared to urban LHDs.[1] Local funding for public health is also often based on the tax base, which is low and declining in many rural areas making local investments in public health difficult.[21] Without meaningful growth in the resources available, it is challenging for local governments to meaningfully invest in public programs.[1]

As noted above, the difference in clinical revenues among rural and urban LHDs is notable, with a mean of $21 per capita for rural jurisdictions versus $6 per capita for urban jurisdictions.[17] LHDs experienced decreases in clinical revenue between 2010 and 2016.[2] Urban LHDs provided fewer primary care services in 2016; rural LHDs provided more mental health and substance use disorder services.[2] Overall, rural LHDs generate more revenue from the Centers for Medicare and Medicaid Services and clinical services than their urban counterparts.[2]

Access to Data

Limited availability or access to data, data quality issues, and limited staff with expertise in informatics and data analysis can also contribute to disparities between rural and urban LHDs. One of the biggest data challenges facing rural areas relates to privacy and confidentiality. While some data sets are publicly available for a large urban area, they may not be publicly available for rural areas due to the small size of the population and the possibility that an

individual would be identifiable based on their condition or other demographic data. Outdated data sets or the lack of real-time data also makes it challenging to understand important local issues and made timely decisions.

Public Health Programs and Services

The 10 Essential Public Health Services (EPHS) provide a framework for public health to protect and promote the health of all people in all communities.[22] The Foundational Public Health Services (FPHS) framework is thought of as the minimum level of programs and services that governmental public health should be delivering in every jurisdiction. The FPHS framework allows for the identification of capacity and resource gaps; determination of the cost for assuring foundational activities; and justification of funding needs.[23] However, it is also recognized that to best serve their communities, LHDs may provide additional services and require capacity in different areas.[23]

Maintaining the capacity to provide the nationally recommended public health services in rural areas can be challenging. Public health accreditation, which incorporates the EPHS and FPHS frameworks within its standards, is seen as an important step to improve the quality and effectiveness of public health services, but a shortage of funds, lack of staff, and insufficient staff knowledge are major barriers for rural LHDs to achieve accreditation. The programs and services provided by rural health departments differ from their urban peers. According to the National Association of City and County Health Officials (NACCHO) Profile Survey, LHDs serving rural jurisdictions are more likely to provide certain clinical services, including childhood and adult immunizations, maternal and child health services, and screening/treatment for various conditions.[17] The result is inequities in public health services across jurisdictions.

Rural Public Health Networks

Unlike urban health departments, which are represented through the Big Cities Health Coalition, there is no national group to which rural public health agencies belong and work collaboratively to advocate on behalf of rural public health and build relationships among staff.[1] The lack of rural public health-focused advocacy has resulted in a lack of focus on rural population health. National public health advocacy organizations typically do not focus on population health needs among rural populations, and national rural advocacy organizations have largely focused narrowly on health care access. While there has been some focus on rural public health challenges, it tends to be issue-specific, such as with the opioid epidemc.[1]

Similarly, while there are federal agencies focused on rural health care, the focus on rural public health is minimal. For example, the CDC does not have a centralized rural office. Rather, the Office of the Associate Director for Policy and Strategy coordinates policy and programmatic efforts across the agency on issues relevant to rural health.[24] In March of 2022, Congress approved a revised version of the Consolidated Appropriations Act (H.R. 2417), which provides funding for the remainder of FY22 and averted a government shutdown. The bill requests the CDC to assess and submit a report within 180 days of enactment of the bill on the agency's rural-focused efforts and strengthening such efforts.

RURAL PUBLIC HEALTH OPPORTUNITIES

Cross Jurisdictional Sharing

Cross-jurisdictional sharing (CJS) is a growing strategy used by health departments to address opportunities and challenges such as tight budgets, increased burden of disease, and regional planning needs.[25] By pooling resources, sharing staff, expertise, funds and programs across jurisdictions, health departments can accomplish more than they could alone.[26] CJS can range from as needed assistance such as sharing information or equipment to regionalization/consolidation, such as merging existing LHDs.[26] The Center for Sharing Public Health Services has outlined success factors, facilitating factors, and project characteristics (i.e. senior level support, effective communication) that can increase the likelihood of successful CJS.[27]

One example of successful CJS arrangements include is two rural upstate New York counties that were struggling to provide public health leadership and services forming a relationship that integrated select functions and services, including the sharing of a director and deputy director, while maintaining two distinct LHDs.[28] The counties also contract together for medical and environmental engineering consulting, share an early childhood transportation provider, and share additional purchasing in some programs.[28] By sharing personnel and functions, management personnel costs have been cut in half and both counties have saved over $1 million for the counties combined.[28]

Challenges have included anxiety among existing staffers who were concerned that their positions may be cut if tasks become shared or integrated. In New York, state legislation also limits how far integration can go, which has limited some efficiencies.[28]

Telehealth

Small, rural health departments have limited access to technology and to information that is available primarily electronically. The inability to provide in-person services because of the COVID-19 pandemic has forced rural LHDs to evaluate different modalities for providing public health services.[14] During the pandemic, rural LHDs used online meeting platforms to provide smoking cessation, diabetes self-management, and other health education classes to multiple counties. This provided a broader population with access to public health services. Telehealth can also help mitigate the lack of transportation, which is a known barrier to care.[14] Anecdotal evidence suggests that technology has allowed LHDs to maintain and expand the reach and scope of the services they provide.[14] While the use of telehealth to improve access to public health services is promising, and could improve health equity, many rural areas still lack high-speed broadband.[29]

Partnerships

Models that stress collaboration among rural LHDs and community partners hold promise for meeting the challenges of rural public health. Building partnerships among LHDs, community health centers, healthcare organizations, academic medical centers, offices of rural health, hospitals, non-profit organizations, and the private sector is essential to meet the needs of these communities.[30] NACCHO has created a guide to share recommendations and stories from the field about developing and maintaining partnerships in rural communities.[30]

EXISTING AMA POLICY

The AMA has extensive policy addressing rural health and access to health care. Policies addressing rural public health are limited to Policy H-465.994, "Improving Rural Health," which states that the AMA will "work with other organizations interested in public health to identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health; develop an advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities."

AMA Policy H-465.994, "Improving Rural Health," also urges physicians practicing in rural areas to be actively involved in efforts to develop and implement proposals for improving rural health care. Policy H-465.997, "Access to and Quality of Rural Health Care," states that the AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. The AMA also supports efforts to place National Health Service Corps physicians in underserved areas of the country.

AMA Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage" calls on the AMA to encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations and develop educational strategies for alleviating rural physician shortages. Policy D-465.997, "Rural Health Physician Workforce Disparities," calls on the AMA to monitor the status and outcomes of the 2020 Census to assess the impact of physician supply and patient demand in rural communities."

AMA Policy, D-465.998. "Addressing Payment and Delivery in Rural Hospitals" calls on the AMA to advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate: create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume; provide adequate service-based payments to cover the costs of services delivered in small communities; adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner; use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability; hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability; and create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone. The AMA also encourages transparency

among rural hospitals regarding their costs and quality outcomes, supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital, and encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.

CONCLUSIONS

With an overall sicker population and larger geographical area to cover, rural LHDs are challenged to meet the needs of their population with less funding and fewer, well-trained staff. Ultimately, residents in rural communities should have equitable access to the essential and foundational public health services provided by the public health system in other jurisdictions.[12] To achieve this, research is needed to determine the needs and models for delivering public health services in rural communities as well as best practices for addressing health behaviors and the social determinants of health in these communities.[12]

While examples of using telehealth during the COVID-19 pandemic and CSJ are helpful, there's little in the published literature regarding successful models for increasing population level public health activities in rural communities. This is likely in part due to rural LHDs having little capacity and funding to participate in research and publish results. Unlike their urban counterparts, rural LHDs also lack a specific advocacy organization.

The lack of health care available in rural jurisdictions also contributes in part to the lack of essential and foundational public health services provided in rural communities, with rural LHDs often left to fill the gap in the absence of other sources of health care. While not directly the focus of this report, the AMA has extensive policy addressing access to rural health care.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. That our AMA amend Policy H-465.994, "Improving Rural Health," by addition and deletion to read as follows:

   1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.

   2. Our AMA will work with other entities and organizations interested in public health to:
   - Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
   - Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
   - Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
   - Advocate for adequate and sustained funding for public health staffing and programs.
   - ~~Study efforts to optimize rural public health.~~

2. That our AMA amend Policy D-440.924, "Universal Access for Essential Public Health Services" by addition and deletion to read as follows:

   Our AMA: (1) supports equitable access to the 10 Essential Public Health Services and the Foundational Public Health Services to protect and promote the health of all people in all communities ~~updating The Core Public Health Functions Steering Committee's "The 10 Essential Public Health Services" to bring them in line with current and future public health practice~~; (2) encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB); (3) will work with

appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards; and (4) will work with the National Association of City and County Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation's public health system, including for rural jurisdictions.

3. That our AMA reaffirm Policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health Disparities."

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3. CORRECTING POLICY H-120.958

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED
See Policy H-120.958

At the June 2020 Special Meeting of the House of Delegates, the Council on Science and Public Health's sunset report recommended that Policy H-120.958, "Supporting Safe Medical Products as a Priority Public Health Initiative" be retained in part and made the changes indicated here:

> Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names;
> (2) continue participation ~~i~~on the ~~National Patient Safety Foundation's efforts to advance the science of safety in the medication use process and likewise work with the~~ National Coordinating Council for Medication Error Reporting and Prevention;
> (3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events;
> (4) vigorously work to support and encourage efforts to create and expeditiously implement a national ~~machine-readable~~ coding system for prescription medicine packaging in an effort to improve patient safety; and
> (5) ~~participate in and report on the work of the Healthy People 2010 initiative in the area of safe medical products especially as it relates to existing AMA policy; and~~
> (6) seek opportunities to work collaboratively with other stakeholders ~~within the Medicine-Public Health initiative~~

~~(H-440.991) and with the Food and Drug Administration (FDA), National Institutes of Health (NIH), United States Pharmacopoeia (USP) and Centers for Disease Control and Prevention (CDC) the Agency for Health Care Policy and Research (AHCPR) and the Centers for Medicare & Medicaid Services (CMS)~~ to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.

The recommended changes were adopted, and the revised policy was recorded in PolicyFinder.

At the November 2021 Special Meeting, CSAPH Report 4 proposed changes to Policy H-120.958 but erroneously proposed those changes to the version of the policy as it had existed before 2020's sunset report. The recommendation found in CSAPH Report 4-N-21 reads as follows:

Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names;
(2) continue participation in ~~the National Patient Safety Foundation's~~ efforts to advance the science of safety in the medication use process, including ~~and likewise~~ work with the National Coordinating Council for Medication Error Reporting and Prevention;
(3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events;
(4) vigorously work to support the Drug Supply Chain and Security Act (DSCSA, Public Law 113-54), including provisions on product identification and verification, data sharing, detection and response, ~~and encourage efforts to create and expeditiously implement a national machine readable coding system for prescription medicine packaging~~ in an effort to improve patient safety;
(5) participate in and report on the work of the Healthy People ~~2010~~ 2030 initiative in the area of safe medical products especially as it relates to existing AMA policy; and
(6) seek opportunities to work collaboratively within the Medicine-Public Health initiative (H-440.991) and with the Food and Drug Administration (FDA), National Institutes of Health (NIH), United States Pharmacopoeia (USP) and Centers for Disease Control and Prevention (CDC) the Agency for ~~Health Care Policy and Research (AHCPR)~~ Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.

We recognize that the starting point for any changes to policy must be the current version of the policy as found in PolicyFinder, which is the June 2020 revision. That policy reads as follows:

Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names; (2) continue participation on the National Coordinating Council for Medication Error Reporting and Prevention; (3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events; (4) vigorously work to support and encourage efforts to create and expeditiously implement a national coding system for prescription medicine packaging in an effort to improve patient safety; and (5) seek opportunities to work collaboratively with other stakeholders to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.

CONCLUSION

The Council on Science and Public Health recommends reconciliation of the amendments to Policy H-120.958, "Supporting Safe Medical Products as a Priority Public Health Initiative," as outlined below. This language ensures that AMA policy supports the Drug Supply Chain and Security Act as addressed in the Council's pharmacovigilance report, acknowledges our willingness to engage with Healthy People 2030 on safe medical products, and streamlines the various federal agencies and stakeholders engaged in this important work.

RECOMMENDATION

Your Council recommends that the following be adopted and the remainder of this report be filed.

1. That Policy H-120.958, "Supporting Safe Medical Products as a Priority Public Health Initiative," be amended by addition and deletion to read as follows:

   Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt methodology to help prevent "look alike-sound alike" errors in giving new drugs generic names; (2) continue participation in efforts to advance the science of safety in the medication use process, including work with ~~on~~ the National Coordinating Council for Medication Error Reporting and Prevention; (3) support the FDA's Medwatch program by working to improve physicians' knowledge and awareness of the program and encouraging proper reporting of adverse events; (4) vigorously work to support the Drug Supply Chain and Security Act (DSCSA, Public Law 113-54), including provisions on product identification and verification, data sharing, detection and response, ~~and encourage efforts to create and expeditiously implement a national coding system for prescription medicine packaging~~ in an effort to improve patient safety; (5) participate in the work of the Healthy People 2030 initiative in the area of safe medical products especially as it relates to existing AMA policy and (~~5~~6) seek opportunities to work collaboratively with other stakeholders to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety.