

## California Public Health/Prevention Physician Leadership Forum

Initial Conference Call Meeting

Tuesday, July 15, 8:15-9:40 am PDT

### Minutes

Call in: (712) 432-1500, Access Code: 545218#

#### 1. Attendance:

Mark Horton took the roll by institution/organization represented. Following were present:

CALIF. ACADEMY OF PREVENTIVE MED:	Hattis	Ronald
	Horton	Mark
	Lyman	Donald
STATE GOVERNMENT:	Chapman	Ronald
	Chavez	Gil
	Mark	Karen
	Watt	James
HEALTH OFFICERS ASSOC. OF CALIF.	Fielding	Jonathan
CALIFORNIA MEDICAL ASSOCIATION:	Clark	Scott
SCHOOLS OF MEDICINE (N to S):		
	Touro West	Catherine
	Wagner	Alesia
	UCSF Rutherford	George
	Seward	James
	McClinton-	
	Stanford Brown	Rhonda
	Loma Linda Orlich	Michael
	Western University Mackintosh	Susan
	UCLA Duvall	Karen
	USC Samet	Jonathan
	UC Irvine Baker	Dean
SCHOOLS OF PUBLIC HEALTH (N to S):		
	UC Berkeley Bertozzi	Stefano
	UCLA (Fielding)	Jonathan: also representing HOAC)

#### 2. Minutes of June 10, 2014 Meeting:

Action: A motion to approve the minutes was approved without objection. Ron Hattis made an editorial change to include the UCI report in Section 3 and to renumbering subsequent sections.

### **3. Future Plans, Structure, and Frequency of Meetings for This Forum (Mark Horton):**

#### **a. Volunteers:**

Mark Horton invited volunteers to help him and Ron Hattis work on structure for this forum. No names were immediately solicited.

#### **b. Future frequency of meetings:**

After the next meeting (tentatively scheduled for September 2), all major topics listed in the initial plan for the forum should have been touched on at least once, and the main objectives will involve follow-up unless new issues arise. Jim Seward suggested flexibility in scheduling future meetings, e.g., routine could be quarterly unless critical issues deserve a sooner meeting, which could then be called by the Chair. Comment on this suggestion was favorable. Mark Horton agreed to quarterly meetings, with additional meetings on call of the Chair, as needed..

#### **c. Future videoconferencing:**

Options were noted, but no specific software or format was suggested.

### **4. Review of California Public Health and Prevention Issues Related to Organized Medicine:**

#### **a. Addressing public health concerns from organized medicine:**

Ron Hattis provided an introduction and rationale for this forum to address resolutions from organized medicine touching on prevention and public health, for which the input and assistance of academic medicine, health officers, and state public health officials would be helpful. CMA staff attempt to follow up on CMA recommendations, and for some resolutions, discussion by this forum could be part of this process. Mark Horton noted the importance of integration between health care and public health, and that CMA has played an important role in this regard. He stated that this forum going forward is an appropriate place for these issues to be considered.

#### **b. Changes in governance at CMA pertaining to public health:**

Ron Hattis again brought up the future CMA review process for resolutions and issues relating to public health. Scott Clark again explained that CMA plans by 2016 (some time after the 2015 House of Delegates) to discontinue annual reference committees that review resolutions for the House of Delegates, including the reference committee on Science and Public Health. Instead, there may be a permanent, year-round council on science and public health, absorbing the functions of not only the reference committee, but also the existing Council on Scientific and Clinical Affairs and some technical

advisory committees on specific subjects such as cannabis. Clark emphasized that public health policy-making aspect of CMA is rated as having high value by CMA members, draws the greatest number of resolutions (25-30/year). He said that a standing committee keeping public health on the forefront within organized medicine will be very important, and this is an appropriate time to provide advance input on its membership structure and potential functions. Its eventual members will be appointed by the CMA Board of Trustees. Mark Horton expressed hope that this group will provide a forum for discussion of these matters.

At the last meeting, Hattis had proposed a resolution *“that this forum support the concept of a standing CMA council on science and public health; that it urge that physicians qualified in public health be a significant component of it; and that CDPH, HOAC, CAPM, and this Forum be consulted about possible candidates.”* However, this had been considered premature and had not been adopted, since there was not yet a voting structure or rules about passage of resolutions. Don Lyman suggested that such a council include physicians with a broad background in public health, and with wide access to public health experts and colleagues within the specialty and from institutions, who could be informally consulted on the questions that come through. Ron suggested at least 3 such physicians, one with experience on the existing CMA entities to be merged, one from medical academia, and a local or state health officer. Clark expressed the opinion that such a proposal would be considered helpful by the technical committee on governance.

Follow-up: Don Lyman will consult the Board of CAPM, which represents public health/prevention specialists within CMA, regarding a formal proposal to CMA on the concept of appropriate representation council on science and public health.

- c. Encouraging greater involvement of Osteopathic Physicians and Surgeons of California regarding public health and prevention issues:  
Ron Hattis said that the osteopathic medical community is a full partner in this forum, and expressed the hope that OPSC will take a similar approach to CMA on public health issues. He praised Touro University’s MPH and joint degree programs. Alesia Wagner and Catherine West said that OPSC has a history of supporting CMA policies on public health. Wagner thought that a representative from the Legislative Committee of OPSC would be an appropriate addition to this forum.

Follow-up: Alesia Wagner and Catherine West will consult current leaders of OPSC about official representation of the organization on this forum.

## **5. CMA Resolutions 103-13 and 104-13 on Immunization Registries:**

Issue: How can CDPH, DHCS, universities, health officers, etc. help implement the recommendations in these two resolutions?

- a. Encouraging medical providers to increase their reporting of immunizations to registries (Resolution 104-13):

Scott Clark deemed this resolution to be an internal request for CMA to encourage registry use by physicians. Ron Hattis asked whether the medical schools are teaching students and residents to use the California Immunization Registry (CAIR), but no schools responded. This will be followed up with an e-mail query. Currently, recording in CAIR requires the duplicative use of an electronic database separate from the provider's electronic health record (EHR), which may be done by nurses or various office staff. Only a small percentage of all immunizations and TB tests given are currently entered. Catherine West suggested quality improvement (QI) projects that include the percentage reporting of immunizations that actually go through to CAIR, in addition to current indicators such as immunizations being up to date. Gil Chavez noted that the system is only as good as the data that is recorded, and that he was happy to see the CMA resolution.

- b. Encouraging medical providers to report tuberculosis screening results Greater use of registries for recording tuberculosis screening in registries (Resolution 103-13):  
James Watt noted that the registry is set up to include TB screening information, and that additional elements can be added, but they are limited by the wording of the statute that added tuberculosis.

- c. Encouraging the use of tuberculosis screening data reported to CAIR by CDPH and local public health agencies for the control and prevention of tuberculosis (Resolution 103-13):  
Scott Clark noted that this arose from public health concerns in L.A. County, to provide preventive treatment to those infected with TB in order to prevent active disease. Watt said that public health agencies have full access, but perhaps the way that the data that are presented could be more useful for public health needs. The system was designed to view individual rather than aggregate data. No new legislation is needed unless additional types of information are to be entered into the system. Fielding suggested that standard and flexible outputs be developed. Fielding also thought that immunization rates by provider are a legitimate public health concern. He and Hattis suggested that CCLHO could be consulted about the type of reports that might be useful to public health. Watt noted that until reporting rates increase, aggregate reports will have limited usefulness.

- d. Linking the patient/provider electronic health record to information exchange with the registry, e.g., for TB screenings (Resolution 103-13):

James Watt said that reporting of immunizations in a registry is considered a component of “meaningful use” of an EHR. CAIR version 2.0, which will be developed over the next 1-2 years, will promote exchange of data with EHRs so that dual data entry will not be required. Jonathan Fielding expressed the need for the default to be automatic recording in CAIR of immunizations entered into the EHR, unless the provider requests an exception. Watt said that the new version will allow bulk data transfer from large information systems, whereas it only allowed individual entry. It will also expand the linkages among the regional component registries making up CAIR. Some large providers are already sending electronic data to CAIR. He asked for support in reaching out to the places where large-scale data exist; and that we facilitate conversations between the Registry and groups that have the data. Chavez said that there is time during the upgrade to work on such communication. He also noted the need to track a child throughout the state.

## **6. CMA Resolutions 108-13 and 128-12 on HIV:**

Issue: How can CDPH, DHCS, universities, health officers, etc. help implement this resolution’s recommendations for the recommendations in these two resolutions?

- a) Supporting and encouraging physicians to follow the recommendations of the Centers for Disease Control and Prevention and the U.S. Preventive Services Task Force, to offer voluntary, opt-out HIV screening to all adolescents and adults (Res. 108-13):

Karen Mark said that the Office of AIDS (OA) is totally on board with these recommendations. There is a full-time specialist on HIV testing in healthcare settings, to provide assistance around the state. AB 446, which went into effect January 1, requires primary care clinics to offer an HIV test on an opt-out basis, if blood tests are ordered for other reasons, and a policy letter and fact sheet on the Web site and OA staff to advise clinics how to implement this. There are not great data on total testing done, because only positive results are reportable, but a survey of major laboratories is planned to help estimate the extent and positivity rates of HIV testing statewide.

- b) Promoting partnerships between public health and private providers that strive to assure that all persons who test positive for HIV are linked to care and treatment, provided with antiretroviral treatment, retained in care, and enabled to suppress the virus for their own benefit and to significantly reduce transmission (Res. 108-13):

Karen Mark said that there is a staff person dedicated to linkage to care and retention in care, who is available to assist healthcare providers. OA is encouraging some jurisdictions with low rates of new infections to divert a portion of screening resources to

linkage and retention of persons found to be positive. CDPH has arranged for some federal Preventive Services Block Grant funds will be used by the Prevention Services group to utilize surveillance data to identify people who are out of care or not linked to care. \$3 million was added to the budget at the end of June for demonstration projects on more effective testing, linkage to care, and retention in care. Jonathan Fielding lauded the New York City model and said that a “big picture” view should call for more resources now, that prevention and treatment almost completely overlap, that there is a way to reduce HIV transmission, with ultimate economic benefits. Mark agreed that this would save money in the long run.

- c) Promoting voluntary linkage of all persons reported with new HIV infections to ...confidential partner notification services (excerpt from Res. 128-12):

Karen Mark said that there is a partner services coordinator. A policy letter for local public health jurisdictions clarifies that state law permits the use of surveillance (reporting) data to reach out to clients and offer partner services. Ron Hattis mentioned a survey by the Beyond AIDS Foundation of local public health jurisdictions in California that revealed gaps and variations in services, related to cutbacks in funding and staff. They also discovered that the list of local public health contacts for partner services on the CDPH Web site was outdated, and it still is. Mark acknowledged the local cutbacks, and hoped that demonstration project funds will help some of these jurisdictions.

- d) Loss of State General Fund Prevention Money:

Gil Chavez noted that all state general fund money for HIV prevention has been totally cut from the budget, and admitted that OA is doing the best it can with reduced resources but cannot do everything it did in the past. Ron Hattis asked for more details after the meeting, so that organizations like Beyond AIDS, CAPM, and CMA could provide support for restoring funding.

Follow-up: Discussion to be continued at September 2 meeting.

## **7. Training Issues Related to Schools of Medicine and Public Health:**

Ron Hattis asked for e-mail input to the previously distributed spreadsheet describing what the 11 medical schools are doing in terms of public health and prevention training.

Catherine West asked about whether medical students who obtain an MPH in a joint degree program or prior to medical school are disadvantaged if they wish to do a residency in Preventive or Occupational Medicine; and also about the advanced public health training requirements for Preventive and Occupational Medicine residents. Hattis explained that the latter can be provided either by the MPH program or through training provided by the

residency program. Jim Seward clarified that the requirements do not need to be provided by transcript courses, as long as training is documented. Dean Baker added that there must be a formal assessment such as an exam. He also clarified that the latest ACGME requirements require 24 months of practicum for each residency, for Preventive and/or Occupational Medicine. This can include time spent acquiring an MPH, but if the resident already has an MPH (or the other residency has been completed), that does not shorten the time. This is a disincentive to obtaining a dual degree or to do residencies in both Preventive and Occupational Medicine. However, Seward said that UCSF had been told that someone with a Preventive Medicine residency only has to do one year of Occupational Medicine residency plus one year in practice, so there is a discrepancy with the written determination given to Baker. West asked if current Preventive Medicine residencies accept physicians who already have an MPH. Baker said that physicians with an MPH may be more likely to go into Preventive or Occupational Medicine, and as long as 24 months of funding can be obtained, a resident with an MPH already can use the extra time to obtain an additional Master's degree or take other courses of interest. Hattis noted that a much larger number of physicians get an MPH degree but not a Preventive or Occupational Medicine residency. He suggested that it is important that MPH programs that medical students or physicians attend should provide a broad background in public health and prevention (not one specialized in a narrow area), and valuable experience that can prepare for a career as a health officer or similar position.

**8. Next Meeting: Tuesday, September 2:**

Mark Horton recommended that in view of the current call lasting longer than the scheduled hour, the next meeting be an hour and a half, to assure adequate coverage of all issues.

Respectfully submitted,

A handwritten signature in black ink, reading "Ronald P. Hattis, MD, MPH". The signature is written in a cursive, flowing style.

Ronald P. Hattis, MD, MPH, Recorder

Minutes approved 9/2/14