California Public Health/Prevention Medical Leadership Forum

22nd Conference Call Meeting

Tuesday, March 19, 2019, 8:15-9:30 am PT

MINUTES

Call in: (515) 739-1015 Access Code: 457-029-043#

Handouts (this agenda and minutes) were distributed as attachments to the announcement email. Other references (online) are included as links below.

1. **Roll Call by Institution, with Introductions of Newcomers**

   California Academy of Preventive Medicine (CAPM): Ronald Hattis (Secretary), Mark Horton (Chair), Donald Lyman
   Department of Health Care Services (DHCS): Karen Mark, Julia Logan
   Health Officers Association of California (HOAC): Kat DeBurgh
   Stanford School of Medicine: Eleanor Levin
   Loma Linda University School of Medicine (LLUSOM): April Wilson
   Western University School of Osteopathic Medicine (WU): Susan Macintosh, Maryam Othman
   UC San Diego School of Medicine (UCSDSOM): Margaret Ryan
   UC Berkeley School of Public Health and Joint Medical Program (UCBSPH): John Balmes
   UC Los Angeles Fielding School of Public Health (UCLASPH): Jonathan Fielding
   Guest Speaker, South Coast Air Quality Management District (SCAQMD): Scott Epstein

2. **Minutes of December 4, 2018 Meeting** (handout)

   There were no additions or corrections.
   Action: Minutes approved as written.

3. **California Department of Public Health:** No representative present. Continuing issues still pending include posting of HIV testing information sheets on new Web site; and publicizing of new public health legislation.

4. **Report on Conference: Impacts of Wildfires on Air Quality and Health (Santa Rosa, 2/13-14/19); and What Should Physicians and Medical/Public Health Students Learn?**
   https://www.awma.org/Files/Wildfires/Wildfires%20Final%20Program%204.pdf

   a. John Balmes, conference speaker, physician member of Air Resources Board, and representative to this Forum from UC Berkeley

      John has been involved in wildfire issues since doing studies on pulmonary function in fire fighters in the late 1980s. Subsequently, he worked with 2 doctoral students on health issues related to wildfires, and published several papers with them. He reviewed points from his lecture at the Santa Rosa conference, and general health issues related to the fires.

A "perfect storm" of coinciding factors have predisposed California to more frequent and extensive wildfires.

- Wildfire season is longer than in the past, and may extend year-round; the Thomas Fire a few years ago broke out in December.
- The decades-long legacy of fire suppression has resulted in a huge supply of fuel; allowing natural fires requires approval by Cal Fire or National Forest Service which have historically opposed them; and prescribed burns require approval from them plus local AQMD, and are politically resisted due to fears of air pollution and losing control.
- Climate change has produced hotter and drier weather; and even rain does not help as much because it causes more vegetation growth, which then dries out and becomes combustible.
- Development has resulted in more homes (and towns like Paradise) near susceptible forests.
- Wildfires release toxic compounds similar to tobacco smoke (including formaldehyde and benzene; and when homes and cars burn, additional toxic products are released.
- Literature on health effects confirms increases in asthma, COPD, and pulmonary infections, as well as increased utilization of services for cardiovascular disease associated with particulates under 2.5 microns in diameter (PM2.5), and mental health (mostly from stress); there are also concerns about effects on pregnant mothers including low birth weight.
- Public health response: best evidence is from the 2002 Hoopa reservation fire; best results among those who stayed home, and used distributed HEPA filters; evacuation attempts (other than escaping the paths of fires) and N-95 respirators were not proven to improve health outcomes in populations as a whole.
- Public health messaging is most effective if simple and consistent; unfortunately during recent Northern California fires, different counties and cities gave inconsistent advice on N-95 devices, with some distributing them and others advising against them.
- Data from the University of Michigan and the University of Toronto, presented at a separate conference in Vancouver, indicate some benefit can be achieved even without fit-testing and even in children for whom they are not indicated and even small adult masks do not fit them well; and some effects even with simple surgical masks designed to protect surgical fields rather than users.
- Further data from the Vancouver speakers (unpublished) suggest that for health people, in unhealthful air, a million would need to wear N-95 masks to prevent one ER visit, whereas for those with pre-existing heart and lung disease, assuming they do not increase the difficulty of breathing, an ER visit could be prevented by 12,000 users of N-95 masks, so while the masks can be optional for all, they should be actively recommended mainly for people with asthma, COPD, heart disease, etc.
- Late adverse effects of fires: housing shortages; risks from cleaning debris; mudslides after rains.
- Air Quality Index (AQI) does not fully reflect level of particulates in the air.
- Recommendations for advance prevention of morbidity and mortality include bulldozed fuel breaks around neighborhoods, smoke detectors, and avoidance of building among trees.
- Longterm studies monitoring health in fire areas are ongoing, a "hot area" for research.

b. Scott Epstein, South Coast Air Quality Management District: comments

Scott was a guest at this meeting. He was a panelist at the Santa Rose conference.

- Approximately ¾ of the conference was on topics other than health effects, such as monitoring air quality and case studies.
- Traditionally, air quality measurements are reported using the AQI, which is based on 3 to 24 hour averages with an averaging period dependent on the methodology, i.e., NOWCAST, and the rate of change in concentration. However, during wildfires, AQI values may fail to give acute warnings; and even 3-hour averages are too long to detect sudden deterioration or a moving plume of pollution. The PM2.5 air quality standards are based on PM2.5 AQI categories, which were utilized in adverse health effect studies over 24-hour AQI averages, with levels over 150 considered to be unhealthful.
- A new approach is to use thousands of low-quality sensors, which give rapid results from more locations, but are less accurate and do not include all hazardous components.
- Air quality forecasting methods were discussed.
- In Missoula, MT, poor air quality from surrounding wildfires can last throughout the summer season, and the county public health department is focusing on implementation of high-quality HEPA filtration in school buildings, to create "clean air spaces."

c. Open discussion on didactic approach for physicians in practice and medical and public health students, residents
   - Jonathan Fielding and John Balmes agreed that mental health issues need more emphasis, including longterm. Behavioral and addiction problems should also be studied.
   - Mark Horton said that public health attention should be given to hazards to be expected after residents move back to a burned area. He also mentioned threats to drinking water safety as systems are taken offline and restored; and health threats related to evacuation and sheltering of patients from healthcare facilities.
   - No suggestions were raised on content to teach students at schools of medicine and of public health.

The speakers were thanked. In the absence of requests to continue the discussion at the next meeting, Mark Horton determined that the topic will be closed, but can be reopened if more information develops.

5. **Health Provisions in Gov. Newsom's State Budget, Public Health Perspective: Kat DeBurgh**
   https://www.cdph.ca.gov/Documents/CDPH%202019-20%20Governor's%20Budget%20Highlights.pdf

Kat reported that she was excited to see that Gov. Newsom seems a little more "into" public health, and health issues generally, compared with former Gov. Brown. An increase of $2 million for STDs has been added. The health officers are lobbying for further increases in funding for communicable diseases. The budget also includes Medi-Cal funding for undocumented persons up to age 26, but this is being funded by taking money away from public health realignment, thus "robbing Peter to pay Paul." Kat thinks the Legislature wants to expand Medi-Cal for undocumented beyond age 26.

Ron Hattis noted that he had an opportunity to talk briefly with Gavin Newsom during the campaign, and informed him that there had been recession cutbacks in public health funding that have never been restored. He also noted that CMA has policy to seek enhanced public health funding and is a potential ally, as a result of CAPM-introduced resolutions a few years ago. Stakeholders can still try to influence the "May Revise" of the budget.

6. Department of Health Care Services: Karen Mark

DHCS has a monthly work group on the opioid abuse problem, in collaboration with the Opioid Safety Work Group led by CDPH, which brings together 40 state and non-governmental agencies.

For primary prevention, the department is focused on reducing "new starts" of opioid treatment, including promoting alternative treatments for pain by reducing requirements for treatment authorization request requirements (TARs); and working with formularies to limit the amount of opioids that can be dispensed in a starting prescription. Secondary prevention focuses on working with managed care providers to encourage them to develop their own prescribing policies, to include review high prescribing and to discourage co-prescribing of opioids and benzodiazepines.

For tertiary prevention, two SAMHSA grant programs related to medically-assisted treatment (MAT) and recovery were described. A $44 million "MAT Extension 1.0" 2-year grant received in April, 2017, is covering a "hub and spokes" program modeled on Vermont, a tribal program for MAT for native Americans and Alaska natives, and expansion of prevention and treatment to 20,000 clients, including treating opioid use disorder as a chronic disease.

A new $68.8 million "MAT Extension 2.0" 2-year grant, received in September 2018, is meant to expand, complement and extend the original grant, and will target native Americans, Alaska natives, service members, veterans, and youth. $38 million will soon be distributed among numerous local entities with new or expanding treatment programs for opioid abuse prevention, treatment, and recovery. Also included is a large program that has been distributing 95,000 free naloxone kits statewide to first responders, law enforcement, shelters, jails, and other organizations. There is a simple online process to apply for a share of these kits. The MAT Access Point project will expand new or expanded access to MAT at 200 sites; $38 million of the grant will be devoted to this.

Mark Horton asked about the Drug Medi-Cal Organized Delivery System project. Utilizing a Medicaid waiver, this supplies an expanded range of services (essentially a managed care plan) under Medi-Cal for opioid use disorder, such as case management and behavioral health. Karen said that this is not funded by the SAMHSA grants. County after county have been enrolling. She offered to bring more information to a future meeting.

On a separate issue, Ron Hattis made Karen aware of the issue of allowing the same physician to be both the HIV specialist and the primary care provider for HIV patients. Such a provision passed the Legislature in 2018 but was vetoed because in Governor Brown's judgement, existing law permitted this. Ron will send the bill number* to Karen to see if she can deal with the issue administratively.

7. CDC and Other Guidelines on Opioid Prescribing and Controversies: Mark Horton

CDC recommendations: evidence for and against; individualizing management
https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fmmwr%2Fvolumes%2F65%2Frr%2Frr6501e1er.htm#B1_down
Fact Sheet: https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf

Mark said that CDC and various medical organizations have classified the opioid epidemic into three "waves": **Wave 1**, believed to often be the first step historically, involves over-prescribing and over-use of prescription opioids, making prescribing guidelines important. CDC has developed prescribing guidelines, as have CMA and various specialty organizations. California is still largely in this wave, making a focus on the CDC guidelines especially relevant. **Wave 2** is when addicted persons increase their exposure to street heroin. **Wave 3** is when fentanyl becomes the major cause of overdoses; this has become a severe cause of mortality in many eastern states, but to date has been less of a problem in California.

There is general agreement that prescribing guidelines are needed, but some physicians have complained that the CDC guidelines are too much of a "cookie-cutter" approach and tend to become legal requirements with enforcement by DEA and the California Justice Department, and that some patients with severe pain have a need for higher dosages than these guidelines provide for. When physicians have rapidly reduced dosages to meet the guidelines, some patients have experienced severe pain, and a few have sought heroin or fentanyl as a solution. Concerned physicians are appealing for acceptance of a more individualized approach. Other medical and health care organizations have developed their own guidelines, specific for different practice settings and practices.

States have also passed laws, such as one in California that requires providers to check the CURES database for patterns of misuse or having other sources of the controlled drug, before and every 4 months after initiating a new opioid prescription. Above a certain morphine mg equivalent, or if co-prescribing a benzodiazepine, a provider in California must also offer a prescription for naloxone. Coalitions in communities working on the opioid problem can consult CURES for data to suggest whether prescriptions are increasing or decreasing. The California Department of Justice is investigating overdose deaths to determine whether inappropriate prescribing was involved.

8. California Medical Association (CMA)
2014 White Paper (accessible only to CMA members, enter login and password)
https://www.cmadocs.org/LinkClick.aspx?fileticket=3Bbufp1w0Qo=&portalid=53

Don Lyman, who chaired the task force that developed the above CMA guidelines, gave brief comments from the perspective of CMA. Don said the good news is that CDC's MMWR publication in January 2019 lists California death rates from prescription opioids and heroin (per 100,000 population) among the lowest among states. A problematic development is that insurance carriers in California are denying coverage when there are deviations from the guidelines..

- Of resolutions listed in last agenda, opposing Parkinson's Disease reporting was disapproved (but CMA staff are asking that burden be eased); others approved with amendments
- Pending Second Quarter resolutions include endorsing yoga therapy, prostate cancer screening without copay, and medical marijuana in schools; and opposing death penalty

9. Osteopathic Physicians and Surgeons of California

Susan Mackintosh (a member, not a current officer) had no report.

10. Health Officers Association of California (HOAC) (up to 4 min.)

Kat DeBurgh reported that health officers are looking for collaborative assistance in accessing full-text medical literature without a high cost. This is available through medical or university libraries in a few places, but in many rural counties, health officers need to keep informed about developments in many specialties but do not have a convenient or affordable means of doing this.

11. Updates from Schools of Medicine

No reports.

12. Updates from Schools of Public Health

No reports.

13. Next Meeting: 2nd or 3rd Tuesday Morning in June 2019

Meeting was adjourned by Mark Horton due to completion of the agenda and expiration of time.

Submitted by Ronald Hattis, MD, MPH
Secretary

*AB 1534, vetoed 9/17/18

The above minutes were accepted at the Forum meeting of July 9, 2019.