California Medical Leadership Forum for Public Health/Preventive Medicine

37th Meeting (10th using Video)

Tuesday, December 13, 2022, 8:00-9:30 am PST

AGENDA

This meeting used a Zoom account from CAPM. Handouts were attached to the email announcement and included the agenda and last meetings minutes.

Meeting started at 0800 with Roll Call to include name, entity represented and title. In an effort to maximize time for presentations and questions and answers, this roll call did not include biographical information unless the attendee was new. There were 21 participants at this meeting.

Vice Chair, Ron Hattis, transmitted Chair Mark Horton's regrets due to an important medical appointment, and began with naming participating entities, asking to hear first from regular representatives, who could then also introduce special guests from their entities. Vice-deans and others associated with curriculum at the schools of medicine and public health were invited to this meeting as guests.

I. ROLL CALL AND REPORTS

California Academy of Preventive Medicine (CAPM) (Sponsoring Entity); no special reports

- Don Lyman, retired PH, lobby/legislative work
- Ron Hattis, CU Science of Medicine, teaching faculty
- Sumedh Mankar?

American College of Preventive Medicine

- Melissa Ferrari

Organized Medicine

California Medical Association (CMA)

- Donald Lyman: besides resolutions discussed earlier, nothing new to report

Osteopathic Physicians and Surgeons of CA (OPSC)

- Anita Gupta: introduces self as new member to group; Anita is a physician in Southern California practicing anesthesiology and pain management with an interest in business and innovation; Dr. Gupta is also a pharmacist.
- Dr. Gupta also shared a contact link in chat: https://www.linkedin.com/in/doctoranitagupta
- Holly Macriss: present but driving during roll call. Anita Gupta representing OPSC today.

Schools of Medicine (Allopathic and Osteopathic)

University of California Davis (UCD)

- Kristen Olson, Pathologist, Associate Dean Curricular Education at UCD SOM
- Brad Pollack, Chair of PH Sciences at UCD in the SOM. Involved in 5 of the programs and the preventive medicine residency in which UCD cooperates with the California Department of Public Health. Dr. Pollack is involved in cancer work and was pulled into the COVID response. The MPH is in the medical school and have several medical students that also join the MPH, but there is not yet a formal dual MD/MPH degree program.
    - Dr. Hattis recommend visiting CApreventivemed.org for a list of all schools that offer MPH as well as past minutes of this Forum's meetings.

University of California, San Francisco (UCSF)

- UCSF, Jyothi Marbin, pediatrician at UCSF and director of Joint Medical Program with University of California, Berkeley.

Stanford University

- Eleanor Levin, Preventive Cardiologist

California University of Science and Medicine (CUSM):

- Joel Arviz-Zavala

University of California, Riverside (UCR)

- Mark Wolfson, Chair of the Department of Social Medicine, Population, and Public Health

University of Southern California (USC)

- Ronan Hallowell, Director of Health Systems and Justice Care longitudinal course

University of California San Diego (UCSD):

- Mathew Allison, professor of Preventive Medicine

Charles R. Drew University of Medicine and Science

- Roberto Vargas, MS/MPH, Assistant Dean for Health Policy and Inter-Professional Education, new member
    - Reported Charles R. Drew University of Medicine and Science has received accreditation as a four-year independent medical school as of October 14th, 2022 and will have its first cohort of third year students beginning in July 2023. Up to now, it has been a two-year school feeding into UCLA.
    - They have had a partnership with UCLA. The Charles R. Drew/UCLA Medical Education Program provides an opportunity to attain a dual MD/MPH degree.

Schools of Public Health

University of California, Berkeley (UCB)

- Jarred Mazzanti, Director of Strategic Initiatives at Berkeley Public Health
- Jyothi Marbin, pediatrician at UCSF and director of Joint Medical Program with University of California, Berkeley.

UCLA:

- Johnathan Fielding, reported that his current focus is working on Climate Change Issues
  - Critical for leaders and those on this call embrace this issue

GUESTS

- Preventive Med resident: Josh Hoffner, CDPH residency

- Dr. Michael Rodriguez: Director of California Alliance of Schools and Programs of Public Health.
  - Dr. Rodriguez was previously at Fielding School of Public Health and David Geffen School of Medicine and UCSF;
  - Project to connect schools across the UC and private sector for ideas to address curriculums upstream, work together to advocate (including with health dept.) to help promote evidence-supported policies. Funding comes from
    1. CA Endowment
    2. CA Wellness Foundation
    3. CA Blue Cross and Blue Shield
  - He offered his contact email: Mrodrequez@phi.org

- **Cynthia Mahoney from Climate Change Now and a member of Voting for Climate Health**
  Cynthia provided information about the importance of voting in the chat, copied below**:**
  - Voting is a SDOH - recognized by the AMA this year. Incorporating civic engagement in health care can be non-burdensome and extremely helpful to patients as individuals via sense of increased efficacy and to passage of policy that advances health equity- e.g., programs like Vot-ER 2. She was pleased to see this in medical education of developing physicians, and wondered what to do about older practicing physicians, many of whom are completely ignorant of the SEDOH, as she herself was before getting involved with climate change advocacy. Can CME programs help?

II. **Minutes of December 13, 2022, Meeting**

Minutes of December 2022 Meeting:

- Minutes were attached to the meeting announcement; 9 topics were introduced and Dr. Hattis noted a wealth of knowledge in those minutes, suggesting members save for reference.

- There were no objections or corrections to the minutes, and they were approved without objection.

III. Special Topic:

This program will focus on the implementation of curriculum proposals for social and environmental determinants of health, and public health and prevention priorities, at schools of medicine and public health, with implications for future continuing medical education.

- Today we will hear from four presenters, who will describe alternative ways to address these issues. The speakers include perspectives from a new school (CUSM) developing its curriculum de novo, an older school (USC) integrating new courses into a longstanding curriculum, and a school introducing new content into existing courses (UC Davis). Dr. Hattis will be the final speaker, introducing some new concepts.
- Copies of slides may be sent to preventivemed@aol.com.

1. **Joél Arvizo-Zavala**, Executive Director, Equity, Diversity, Inclusion, and Partnership, California University of Science and Medicine (CUSM) presented: ***New Curriculum at a New Medical School, The*** ***Change Program & College Colloquium***:

- CHANGE (Community Health Advocacy, Navigation and engagement experience) : Program began in fall 2021 as pilot program.
  - Part of required pre-clerkship program (18 months)
  - Includes 11 community partners, in structurally vulnerable LA County; Students are partnered with one of the 11 community partners.
  - CHANGE program includes introduction to methods & models of community engaged research, assessing needs and strengths of communities, recognizing strengths in addition to weakness
  - Effective Community based Health Project Management
  - Recognize that anti-racism and anti-oppressive foundation to community health education.
- College Colloquium: 3-year multi-disciplinary course designed to strengthen student's core identity as physicians.
  - Integration of social medicine and medicine humanities ○ Development of caring, thoughtful and empathetic experiences ○ Four areas of practice development, patient experience, health systems and community health.
  - Colloquium curriculum has focus on understanding importance of emotional intelligence. Areas of focus include: Emotional intelligence, cultural humility, SDOH, implicit bias, LGBTQIA+ medicine (introduced as a highly underserved community), medical ethics, obesity and overweight, stigma and barriers to SUD treatment, reproductive health care and structural competency and healthcare systems.

- Core Model Approach across entire university that is connected to the mission and vision of the university; Includes internal and external partners and presenters including physicians, health care professionals and community leaders with lived experiences. Focus on structural competency, social determinants of health and community-engaged learning. The model includes reflections, reflexivity, and critical self-reflection.
  - Focus on community engagement and development
- Lessons Learned from the CHANGE and Colloquium Programs
  - As a new university, CUSM has been able to gain a thoughtful balance between biomedical sciences and academic efforts of CHANGE and colloquium. Faculty engagement has been important for the student experience.
  - Students are learning to navigate a more robust set of learning expectations
  - Perspectives are mirrored in co-curricular programing through LEAAP, which is required for students, faculty, and staff.
- LEAAP: Learning & Engagement for Anti-racism & Anti-oppression

Practice

  - Continual adjustments are necessary to meet learning needs of students and faculty.
- Opportunities:
  - Expand community-partner engagement through lectures and professional development
  - Expand reach of outside experts to present on topics; Students love this component.
  - Continue to support co-led learning opportunities to develop leadership opportunities in students
  - Strengthen link between community-engaged learning and assessment of public health.
- Dr. Hattis, who has been teaching part-time at CUSM, said he has been impressed that the Colloquium course for first-year students includes health systems science, including insurance and funding, comparisons with other countries, and public health (although he thinks that the latter is under-emphasized).
- Dr. Hattis provided an anecdote about student reactions to teaching about racism and discrimination. Dr. Keith Norris, a two-time guest speaker at this Forum from UCLA, taught about structural racism there, and related that about 1/3 of students were a bit resistant, about 1/3 were interested and engaged, and about 1/3 thought it was not strong enough and that they should be "marching in the streets now."
  - He asked whether some students feel that this curriculum is detracting from their actual clinical instructional time. Dr. Arvizo-Zavala responded that some students enter with a specific idea of what they think medical school will be like, based on historical patterns. As these experiences grow, CUSM is attracting more students who are interested specifically in this curriculum, and over time CUSM expects to see more of this type of student at their school.
  - There was a question about compensation to community partners when students are embedded into community partner locations. CUSM has funding to support the community partners; For example, they reimburse organization that has to conduct extensive background checks before students can attend. They also set aside funding for other costs that arise for the community partners.

- Dr. Arvizo_Zavala provided his contact information in chat: (909) 297-4696 and arvizoj@cusm.org

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2. Ronan Hallowell, EdD, MA, Director, Health Justice & Systems of Care MD Course; Keck School of Medicine, USC presented ***Health Justice and Systems of Care, New Course at an Older Medical School:***

- Purpose of the addition to the curriculum is to empower students to effect transformative changes in their practice, health systems, policies and broader structures, that lead to health equity & racial justice in medicine.
- The learning outcomes include cultural humility/recognize their own bias, to recognize inequities in the clinical setting and in the structures that impact our health, learn to assess and refer or treat patients for their social needs in the context of communities they live, advocate for policies, programs and structural change that will improve health equity and become more empathetic physicians.
- USC established a longitudinal course across all 4 years.
  - Pre-clerkship: 21 sessions for 2 hours, typically a guest speaker followed by small groups; Focus on problem recognition and identification (required)
  - Seminar: Health justice and systems of care with focus on solution identification and integrations; This is a 2-week full time session, before start of clerkships. (required)
  - Post-clerkship: health justice and systems of care with focus on learning and experience applications, and an emphasis on advocacy and policy; 4 weeks full-time curriculum, and another 4 weeks can be provided for a scholarly project (select cohorts, optional)
- The overarching domains include foundations of health justice, structural & social determinants of health, service-learning, health systems and policies, patient safety, quality improvement, high-value care, and advocacy for health justice.
- This curriculum came about as a response to AMA's Health Systems Science emerging from Systems-Based Practice concepts from ACGME. Opportunity to advance these topics in the Systems Based Practice and recognized Health Structures were primary to their needs. USC found it valuable to be part of the national conversation, including Health Justice.
- The timeline to build this included completion of LCME accreditation in 2017. An initial HSS pre-clerkship was launched prior to this. Once accreditation occurred, this became required training.
  - Top leadership, including the Dean of the school, were highly supportive of the course, which helped integrate it into the curriculum. The support of the university was instrumental in the success of this integration.
  - 2018 began an initial planning and by 2019 there was curriculum renewal committees to start formal planning process
  - 2020, there was strong student interest and curriculum renewal planning continues
  - 2021 Curriculum Renewal Launch
  - 2022 Completed first pre-clerkship cycle; Use student feedback and adjust with continuous quality improvement. There has been some faculty pushback but well received with further distance to go.

- Faculty recruitment, integration with other parts of the curriculum, faculty development and continued leadership support and funding are necessary to program sustainability.
- The course is led from the Department of Medical Education

- Dr. Hattis asked which subjects 'lost' time in order to include the new course material ○ This is difficult to quantify; Some of the material was in existence and was reorganized and did not take up additional time.
  - Moving from 2 years to 18-month curriculum may have created a larger issue due to compression of the time. It is not clear how they directly took other 'real estate' out of the medical curriculum.
- Dr. Gupta mentioned an undergraduate master's students at Princeton focused on public policy, which includes about 2-4 weeks pre-med. Dr. Gupta wondered about how this could apply to a 'pre-med' social justice program. Due to time constraints Dr. Hallowell will follow up.
- Dr. Hallowell provided his contact information in chat: ronan.hallowell@usc.edu

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3. Kristin A. Olson, MD, Associate Dean for Curriculum and Medical Education UCD School of Medicine (SOM) gave a presentation on modifying the content of pre-existing courses and lectures titled ***Revisiting the Essentials: A SOM Approach to Longitudinal Curricular Incorporation of Health Equity and Social, Structural and Environmental Determinants of Health.*** Dr. Olson reviewed what they have done previously at UCD and how they have changed to current approach.

- Health Equity has been a priority at UCD and taught in various formats over the years. They have a strong primary care focus. It was included in one of 30 separate courses in the pre-clerkship phase of medical school. "Legacy Curriculum" was in place up until 2021.
  - The challenge was that students felt they learned it in an isolated 'chunk' of time but not seeing it integrated to other subjects.
  - Advantages of curriculum reorganization included efficiency and dedicated time for faculty.
- The I-EXPLORE pre-clerkship was a restructuring that includes 7 sequential highly integrated courses.
  - Health equity content is longitudinally incorporated into each of these 7 courses:
- Human Architecture and Function, Molecular and Cellular Medicine, Pathogens and Host Defense, CV, Pulmonary & Respiratory Systems, Endocrine, Reproduction & GI systems, Skin & Musculoskeletal Systems, and Brain & Behavior.
- The first 3 courses are foundational with core concepts that segue into systems-based learning.
- They chose a longitudinal approach because it emphasized long-term understanding and retention and incorporated concepts from the educational literature, including scaffolding, interleaving, spiral curriculum and integration.
- Scaffolding provides a foundation and builds on it over time.
- Interweaving provides small amounts over time and returning to topic and building upon it rather than isolated blocks of content.

- Spiral curriculum begins with a foundation, building and revisiting key concepts.
- Integration: the ideal approach needs to be school-specific based on their needs. The curriculum committee should discuss this.
- I-EXPLORE
    - Health equity and social/structural/environmental determinants of health is under the umbrella of Health Systems Science, which is one of 3 curricular pillars.
    - Each course has 3 course directors: biomedical science, clinical science and health systems science. The 3 directors advocate for the inclusion content belonging to their pillar
    - Funded educators with specific expertise in health equity and social/structural/environmental determinants of health take lead in teaching the content.
    - Spiral 'roadmap' of health equity developed with planning including conceptualizing the right topics to start with and how to build upon them over time, identifying integration opportunities.
- It is important to understand history and context and how we can do better, advocate for change, and properly care for patients going forward.
    - Material includes concept-specific lectures and readings along with required active learning session that incorporate health equity as a recurring component of the session. These include:
- Problem-based or team-based learning, patient panels, journal clubs and peer teaching can be included.
    - Examples include a case on pancreatic cancer that could discuss modifiable and non-modifiable risk factors, or social factors affecting a pediatric asthma case.
    - Curriculum committees must have an effective mechanism to revise curriculum and prioritize content.
    - Faculty recognize merits of the approach while also experiencing varying confidence levels with the content. Program has been helpful for broadening interest across faculty.
    - Important to recognize inherent challenges in collaboration and integration.
    - Students have expressed appreciation for revisiting health equity content more frequently because it reflects their values and realities in caring for our communities.
- Dr. Olson provided her contact number to take questions due to time constraints: kriolson@ucdavis.edu

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4. Ronald P. Hattis, MD, MPH. Associate Professor of Preventive Medicine, Loma Linda University and of Medical Education CUSM presented ***Ask It, Then Task It: Integrating the social and environmental determinants of health into medical histories and practice***.

- Connecting the dots (in medicine) tends to get missed. Courses such as those already discussed help students be aware that there are people 'out there' suffering from Social Determinants of Health but we often do not realize that the patient in front of us is one of these.
- Generally, these topics are introduced but are separate from the history and physical (H&P) and the clerkships, so they are not integrated into medical encounters.

- Environmental determinants are important, and we should be talking about social and environmental determinants of health. (SEDOH, social and environmental determinants of health). Climate change, wildfires, heat and cold emergencies, floods, etc. impact low-income communities and persons of color more than affluent portions of the population. There is also a concern about environmental justice.
    - Therefore, new questions need to be asked when taking a medical history, but we need to be careful not to unduly lengthen the duration of the clinical visit.
- Questionnaires can be used to identify these SEDOH. Dr. Hattis noted that in most medical offices, long health questionnaires are filled out by new patients and by those returning for annual visits. However, more often than not, these are scanned in by office staff and never seen by physicians, or not reviewed with patients during their visits.
- In the chat, Dr. Olson referenced work by Stephany Sanchez at UC Davis on work by the AMA and several medical schools (including UC Davis), expanding the H&P to address social needs (a project called "H&P 360"). Early results are promising. See https://pubmed.ncbi.nlm.nih.gov/32769457.
- Dr. Hattis thanked Dr. Olson for this lead, and commended her for privately concurring that when teaching about a disease, this should include its prevention and epidemiology, and the effects of nutrition and lifestyle, risk factors, etc. When epidemiology and biostat is isolated in a block, it may rarely be thought of again after taking Part I of the boards.
- Traditional medical history questions do a good job of assisting in reaching a differential diagnosis, but do not typically adequately address SEDOH.
    - Dr. Hattis gave an example of asking a patient not only if she drinks alcohol but also whether there is alcoholism in the family. That is not part of the patient's diagnosis but affects home stress and potential patient adherence to recommended care. Patients are not routinely asked if they have sick leave to attend medical appointments, or have transportation challenges. There are many other SEDOH examples.
- The differential diagnosis begins with the chief complaint, and guides further history of present illness questions, what portions of a physical exam are done, what tests are ordered, etc. As we progress in a patient assessment, we are utilizing epidemiology, but we don't always teach that.
- If we find these challenges, we can generate referrals, initiate telehealth visits, address lifestyle and nutrition at every stage of the disease and every specialty.
- Dr. Hattis proposed a research project involving 2 or more schools with representation from faculty, students and residents to develop a new templated for medical questionnaires. As these are reviewed during the visit, they should guide the medical history. He recommended field-testing this model to evaluate indicators of improved patient care, patient satisfaction, sense of well-being, etc.
- Dr. Hattis shared the California Academy of Preventive Medicine recent Policy Resolutions that recommended bringing SEDOH into the clinical encounter. He believes this may be an area of accreditation requirements in the future. He encouraged any involved with residency training, continuing medical education programs and schools of public health to consider these topics.

- Dr. Vargas noted Dr. Mahoney's chat statement about utilizing ICD10 codes and suggested also consideration of how to merge this work with billing related V-Codes developed to integrated SDOH into the electronic health record (EHR). He has a post-doc fellow working on this, and they find that only about 2% of Medicare claims or problems include V-Codes and only about 4% of Medicaid include them, despite the likelihood that most Medicaid patient qualify for relevant codes.
- Dr. Hattis also proposed that the EHR could help guide providers, with drop-down menus to suggest differential diagnosis, and others in the medical 'plan' that would ask about SEDOH and about preventive actions like screening tests, nutrition, and lifestyle. This could be useful for physicians already in practice.
- Dr. Hattis offered his contact email: preventivemed@aol.com

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Final Discussion:

- Cynthia Mahoney commented that she is impressed with this work and what young students are incorporating but we could consider another session on older physicians who have never heard about SDOH.
  - She noted that about 1/3 of the practicing providers are this 'older' generation and she is wondering how we go about helping change their awareness.
- Dr. Hattis suggested that this could be a topic for a future meeting. He also noted that as the younger students go out, their duties as residents and in medical groups lead them in the traditional direction; and providers are not being paid for extra time dealing with social and environmental determinants of health. He suggests including environmental determinants along with social (social and environmental determinants of health or SEDOH).
- This Forum has a focus on prevention, and as SEDOH are detected, we can explore preventive mitigations that physicians can implement.

Next Virtual Forum Meeting, Tentatively Tuesday morning, March 14, 2023

These minutes were submitted by Traci Stevenson with some editing by Ron Hattis, and were approved at the 3/14/23 Forum meeting.