California Medical Leadership Forum for Public Health/Preventive Medicine
42nd Meeting (15th using Video)
March 12th 2024, 8:00-9:30 am Pacific Time
MINUTES

This meeting used a Zoom account from CAPM with phone access provided. "Handouts" (i.e., the agenda, last meeting's minutes, and slides from Yingjia Huang's presentation at the December meeting, DCHS on Medi-Cal expansion) were attached to the email notice. All attendees except those participating by phone could enter information in "Chat." Web references for agenda topics were embedded in the agenda.

Dr. Hattis officially began the meeting at 8:07, noting that this is the 10th year since this Forum began. This may be the first meeting addressing gun violence, a uniquely American problem.

I. Approval of Minutes:

Forum Secretary Traci Stevenson made a motion for approval of minutes from the December meeting, which included presentations from two leaders from the Dept. of Healthcare Services on the expansion of Medi-Cal and the CalAIM program. This was seconded by Dr. Rutherford. Participants demonstrated in favor by raising hand via zoom and/or unmuting themselves. There was no opposition.

II. Special Topic Presentations, Preventing Gun Violence, Part 1:
Julie Parsonnet MD, Professor of Medicine and Population Health, Stanford. *"Gun Violence as a Medical and Public Health Issue"*

a.1. Dr. Parsonnet prefaced her talk by highlighting work done by Dr. Amy Barnhorst who will be providing the second special presentation today.

a.2. There are about 50,000 deaths, including slightly suicides than homicides in the US each year, with some other scattered types of other gun violence and deaths.

a.3. Dr. Parsonnet highlighted the document "Reducing the Health Harms of Firearm Injury" by the Aspen Health Strategy, noting it is an excellent document written by Megan Ramney from Yale, Emmy Betz from Colorado, Garen Wintermoot from (UC) Davis, Cassandra Krafasi from Johns Hopkins, Greg Jackson, the Deputy Director of the Gun Violence Center at the White House, and Kyle Fisher. There will be another community violence prevention program in Baltimore (a QR code/link to the document was included in the slide deck). The Aspen group came up with '5 big ideas':

a.3.a. The health sector should lead in the effort to reduce the harms of firearm injury.

a.3.b. The right to keep and bear arms should be understood to encompass responsibilities that promote firearm safety.

a.3.c. Firearms should be less readily available to people at risk of self-harm or harming others.

a.3.d. Models that reduce levels of community violence should be supported and expanded.

a.3.e. The nation should close the information gap that impedes our ability to reduce firearm injury.

a.4. California is doing comparatively well.

a.4.a. We have the strictest gun laws in the country and when it comes to firearms, injuries, and deaths. However, there are still far too many. Compared to the rest of the country where there has been a major increase in firearm mortality, California looks relatively better.

a.5. "Guns don't kill people: easy access to guns by people at the wrong time kills people."

a.5.a. The Aspen document and other research consider those at risk including:

a.5.a.1. Those with a history of domestic violence

a.5.a.2. Histories of interactions with law enforcement (including things like DUI)

a.5.a.3. People who are angry

a.5.a.4. People who are impaired by drugs or alcohol (40% of firearm injuries are related to impairment)

a.5.a.5. People who are depressed

a.5.a.6. People under intense stress such as financial, divorce, things that cause people to act impulsively

a.5.a.7. People with dementia

a.5.a.8. 40-50% of people with these conditions live in households that have firearms.

a.5.b. There are over 400 million firearms in the country and it is very easy to get access including to a "ghost gun."

a.5.b.1. As public health workers we need to think about how we can interrupt that easy access for people who really shouldn't have continued access.

a.6. Dr. Parsonnet noted that as physicians and public health people we have an obligation to address these issues.

a.6.a. Conversations can be challenging within a doctor-patient relationship. This requires the doctor to be knowledgeable about firearms including knowing why people own guns, what guns are, how to lock them up and why people don't lock them up.

a.6.b. This is not a one-time but longitudinal conversation that can help reduce risks the same way we address reducing risks of children taking medications out of cabinets, or not having or using child car seats, drunk driving, etc.

a.6.c. Three major areas we can help reduce risk include:

a.6.c.1. Safe storage and how to keep guns away from people not in a position to use them, lock guns with ammunition separately or with a number of mechanisms for safe storage.

Advise off-site storage for people under stress during times they are not in a position to safely have a gun. This requires providers to know who is at risk and to have the opportunity to speak about this with them.

a.6.c.2. GRVO: If necessary, implement gun violence restraining orders.

In California, physicians are not able to invoke a GVRO as this is restricted to family members, police enforcement and a few other people. But we can talk to families about this if they think someone in their family is at risk.

a.6.c.3. Hospital Based Violence Intervention Programs

Begin once an event occurs. A team works in a network surrounding gun violence cases to prevent gun violence in communities.

a.7. Firearms Curricula in Medical Schools

a.7.a. There are more than 154 medical schools in the US but in a 2019 AAMC survey, only 41 medical schools reported firearm content in curriculum, 78 schools did not report relevant content and 35 schools did not participate in the report.

a.7.b. Of those addressing gun violence education, there were few details, but schools typically reported addressing gun violence from perspective of prevention.

a.7.b.1. It is usually taught in year one or two (pre-clinical education).

a.7.b.2. Some teach about it in interviewing in the clinical years, but not many and the total time is low.

a.7.b.3. Considering that gun violence is the leading cause of death of children in the US, it should be extended. It is taught much less than other important topics such as cost consciousness, nutrition, opioid and addiction medicine.

a.8. Dr. Parsonnet concluded by noting she is President of SAFE (Scrubs Addressing the Firearm Epidemic. She showed a slide with her husband, Dr. Winslow, speaking to Jackie Spear, one of the founders of SAFE.

a.8.a. SAFE was founded by medical students after Stanford after a string of mass shooting.

a.8.b. There are 67 chapters in medical schools working to build gun violence education programs, to have curricula, ensure grand rounds and education in clinics so patients have information to take home with them.

a.8.c. Aside from education, the primary purpose, SAFE also leads advocacy efforts, work with legislators to help them understand epidemiology and risk factors and are also working direct to consumer public service announcements much like cigarette education.

a.8.d. SAFE has bi-annual events, the next is April 3rd via Zoom with Greg Johnson, Deputy Director of Gun Violence of the White House Office on Gun Violence Prevention, and survivor of gun violence.

a.8.e. https://www.standSAFE.org has links and further information.

a.9. Questions and Answers:

a.9.a. Dr. Hattis inquired what year the survey was conducted. Dr. Parsonnet replied that it was for the 2019/2020 curriculum.

a.9.b. The upcoming on-line event will be recorded and available on the StandSAFE.org site. Dr. Parsonnet also noted that Dr. Winslow had done many of the events including at MSU as well as collaborations with great people such as Granelia Griggs from Mass General and Sandy Mackay from U. of Texas. Recordings are on the website.

a.9.c. Dr. Hattis asked how many of firearm deaths related to impairment were due to alcohol. Dr. Parsonnet stated that about 40% were related to alcohol with more if other drugs are included. Johns Hopkins has done a large amount of work with a focus on the intersection between drugs and the actual victims and perpetrators having drugs or alcohol in their system. Dr. Parsonnet added that gun violence is at the intersection of people who shouldn't have guns and the ability to get guns really easily.

a.9.d. Dr. Hattis asked if a bill in California legislature to make 3D guns illegal passed this year. Dr. Parsonett was not familiar with that specific law but indicated California is pretty good at passing gun safety laws.

a.9.d.1. She noted, however, we have done a bad job at implementing restraining orders as part of the GVRO (gun violence restraining order) bills. She stated it's not done very often or few people know how to do it. She added that the way it is currently framed we need to expand our education dramatically or do something better with the law to improve it.

a.9.d.2. We also do not have good systems of where people can leave their guns. People don't want their guns taken from them by law so there is a lot of interest on where they can be kept safe. We need a better system of letting people know where they can put their gun if they want it out of there house.
a.9.d.3. Dr. Parsonnet provided a link to gun related bills in California in the chat: https://bit.ly/43hs.jP6.
a.9.e. Dr. Hattis also asked how data are tracked for gun related mortality. Dr. Parsonnet noted there are troubles with obtaining data on gun violence. The CDC is dependent on funding with certain limitations that affect ability to do good surveillance. She noted that categories for deaths are not always correct but thought they are not too far off, but we do not have good data for injuries.
a.9.e.1. There are more injuries than deaths, but we do not have a good context of what the injuries were, what the causes were, etc.
a.9.e.2. The gun violence archives go thru any information they can find and post on their archives. They have the most detailed information on injuries by going thru websites and any sources they can find for data.
a.9.f. Dr. Parsonnet posted a link to their on-line courses (also available at StandSAFE; the first course is on epidemiology, and it being upgraded with the new one to be released in April. The second module is about weapons and gun locks. The third module is about clinical response to gun violence. These are being upgraded with standardized patients.

a.9.f.1.i.a. Clinicians and Firearms: https://mededucation.stanford.edu/courses/physicians-and-firearms2020/

a.9.f.1.i.b. Dr. Parsonnet noted that it is hard to increase gun violence in medical school curricula due to competition for time for other priorities. Dr. Hattis suggested approaching the pediatrics department and Dr. Parsonnet noted pediatrics are doing the best job. Santa Clara Valley Hospital is doing a fantastic job providing education to their clinicians and medical students. She has also been pushing to include gun violence in Grand Rounds, there have been 2 grand rounds in pediatrics and internal medicine.

a.9.f.1.i.c. Program by Cornelia Griggs on how to talk to patients is being sold to the Mass. Medical Society and the NEJM is going to take ownership of it and have available for people to use.

a.9.g. Dr. Hattis opened up for questions from anyone else in the audience, noting that Dr. Dean Winslow helped found SAFE with Dr. Parsonnet.
a.9.g.1. Dr. Winslow said that today's talk succinctly laid out the issues we are facing in the US. He added that doctors, military, and police officers have the most credibility when talking to people about gun violence and we should use our 'bully pulpit.' Part of what SAFE is doing is educating doctors and healthcare providers about the tools they need to be knowledgeable about firearms and related issues.
a.9.g.2. Dr. Hattis asked if any states still have prohibitions on doctors talking to patients or parents about gun safety. Dr. Parsonnet stated there are no such prohibitions at this time, although previously Florida did.

a.9.g.3. Dr. Rutherford added they had a research group based at the Zuckerberg/SF General Hospital that did work on gun violence and recidivism, but he is unaware of the status of this work at this time. Dr. Parsonnet stated that programs on recidivism are really effective but are very expensive. Prevention of recidivism is more cost effective than overall prevention of gun violence itself, but the programs are challenging to maintain.

a.9.g.4. Cynthia Mahoney wondered if there was work going on with the VA hospitals. Dr. Parsonnet stated they work with medical schools and indirectly with VA thru medical school affiliations. She noted Dr. Winslow is a veteran and speaks with veteran's groups and this is an important area. Dr. Winslow added that veterans are an important group, and he was thinking he should talk to Mike Kazal and the local VA Hospital to hold some sessions for the primary care doctors who are on the front lines. He noted firearms are the means of choice for suicide by middle-age and older veterans. Dr. Hattis added that we speak about education in medical schools and residency, but there is little continuing medical education on these topics for the majority of the medical workforce who are already in practice.

(Part II of the Special Topic Presentations on Prevention of Gun Violence, by Amy Barnhorst, follows the Roll Call.)

III. Roll Call and Reports by School, Organization, or Agency:

a. <u>California Academy of Preventive Medicine (CAPM)</u>

a.1. Sumedh Mankar: Forum Vice-Chair; Currently works for Promise Health Care part of Blue Cross Blue Shield serving Medi-Cal members in San Diego and Los Angeles Counties.

a.2. Don Lyman: Don will be at the California Medical Association (CMA) Council on Legislation this weekend, representing CAPM. CMA staff have identified about a hundred bills on health issues and have been working to decide which ones CMA should support or oppose. Don invited everyone on the call to let him know if there is specific legislative action they would like them to pay attention to. If there is specific action you would like them to focus on, please let Ron Hattis know within the next day or two. Don noted that what we do in California legislation can influence what happens in Washington.

a.3. Ron Hattis: Forum Chair, noted that the forum (CaFPM) has not taken positions on legislation itself, but that it is sponsored by CAPM, which does, and is made up of separate entities that may. Ron put his email address into the chat: preventivemed@aol.com

a.4. Susan Bradshaw: Past-president of CAPM, has worked for years on smoking-related issues.

c. <u>American College of Preventive Medicine</u>: Eric Oyan: Eric stated they (ACPM) have some policies and their position statement related to gun violence on their Website. He stated that from a national perspective the gun issue is tough to move forward in Washington considering the amount of money involved with the issue. In terms of public health hey do think it is something that needs to be addressed.

d. <u>California Medical Association (CMA)</u>: Alicia Sanchez: As Director, Strategic Engagement, she staffs the Council on Science and Public Health and will attend the Council on Legislation.

e. <u>Osteopathic Physicians and Surgeons California (OPSC)</u>: Anita Gupta: Dr. Gupta shared that she has been participating throughout the country in opioid education including California Academy of Family Practice Core Collaborative. Dr. Gupta

expressed importance in continuing to understand the opioid crisis persists. She is happy to help educate and discuss with anyone who may be interested.

f. State Of California: <u>California Department of Public Health (CDPH)</u>: Jessica Nunez de Ybarra: CDPH Office Policy and Planning and Community Health Administrator.

1. Dr. Nunez de Ybarra shared a link to report on state of public health that was recently published noting continued high rates of homicide and suicide and that guns are used in most cases: State of Public Health Report: https://www.cdph.ca.gov/Programs/OPP/Pages/State-of-Public-Health-Report.aspx

2. Jessica also notes regarding gun issues that trust is important and there is work by clubs, schools and teaching including on-line trainings. She wondered if there were on-line links to trainings that we could share at the population or public health level. She would be happy to make trainings available to team members at the Department of Public Health and at local levels, noting this is an area where there are often clusters of need, and she is open to promoting trainings for the public or workers in this space.

g. Medical Schools

1.1. <u>Touro University California:</u> Traci Stevenson; Dr. Stevenson shared that Touro has developed Standardized Patient cases that address structural determinants of health including domestic violence and gun violence. This includes a panel discussion, for which, Dr. Winslow participated. Dr. Stevenson is extremely grateful that Dr. Winslow participated. She noted it was because of these Forum meetings that she learned about SAFE, and this collaboration was able to occur. Touro also has started a SAFE Chapter.

1.1.a. Dr. Hattis stated he is interested in topics that become integrated into history and physical taking related to Social Determinants of Health and noted that CAPM has been pushing to get the language expanded to Social and *Environmental* Determinants of Health as many environmental issues are overlooked. He noted environmental risk factors as well as gun violence and many other risk factors should be included.

1.1.b. Dr. Stevenson noted they use the terminology *Structural* Determinants of Health in attempt to include not just social determinants of health but upstream factors including environmental determinants. She noted TU has their students use the PRAPARE screen, used by many federally qualified community health centers to try to capture a whole range of risks, not just gun violence, but it doesn't necessarily pick up environmental issues. Thinking like a D.O., she notes, if we don't fix our environmental structures none of the other public health issues are going to be helped in the long run.

1.2. <u>Stanford:</u>

1.2.a. Eleanor Levin: Dr. Levin shared she is happy to be the conduit Julie and Dean to speak from their university because the work is original and transforming.

1.2.b. Julie Parsonnet: Guest Speaker, see above.

1.2.c. Dean Winslow: Co-founder of SAFE, see above.

1.3. USC: Joe Marie Riley is part of Population Public Health at USC and also part of the Department of Family Medicine. She agreed that working with pediatrics is a good strategy to address gun violence in the curriculum. They have been addressing gun violence with their residents and thru grand rounds and just had 2 grand rounds one with family medicine and one with pediatrics. They are also trying to get it into the Emergency Department.

1.3.a.a. In terms of the curriculum, they have an hour in pre-clinical time to discuss gun violence. They also have an MD/MPH program with 32 students involved this year. Gun Violence is a big part of the curriculum for MD/MPH program.

1.3.a.b. They also have made strides and continue to push forward in the topic of substance use disorder and they have a new center that is working on substance use disorder that work on putting together monthly grand rounds, bring in expert speakers and they have 3 new electives and as well as work in the emergency room to better address the opiate epidemic in a public health forum at their medical school and residency.

1.4. UC Davis: Kristen Olsen is Associate Dean, Curriculum and Medical Education. Amy Barnhorst is our guest presenter, next on the agenda.

1.5. UCSF: George Rutherford reported that they are expanding their preventive medicine residency. Separate from the Kaiser residency, they are expanding UCSF Fresno program and will have positions for 2 residents (one for year one and one for year two) starting in July.

1.5.a.a. The residents will work with the HRSA grant, primarily at the Fresno County Health Department and also with a FQHC (Federally Qualified Health Center) and hopefully some time in Madera and Merced, where UC has a new campus and some public health courses.

1.5.a.b. Currently, residents will get their MPH from Cal rather than Fresno State. A few years ago, when there was a budget surplus, Mark Alley had been clear about wanting UCLA to expand into Bakersfield and UCSF to expand into Fresno. They have been able to begin this in July.

1.5.a.c. He noted there is a new UC campus, called UC Merced (Joking they should have called it UC Yosemite). They have a public health minor at this time. Regarding Madera, there is a children's hospital.

6. UCLA: Conversations have begun with Kern County Dept. of Public Health about a future Preventive Medicine residency program. Strategically, they are not ready for this yet, but have started sponsoring some preventive medicine and public health educational activities.

h. Guests:

1. Cynthia Mahoney works on climate issues, and recently on voting issues, with the Civic Health Alliance and others.

2. Jacqueline Peretti is a Preventive Medicine resident at UCSD/SDSU in San Diego. She appreciated the opportunity to attend this meeting.

IV. Special Topic Presentation, Preventing Gun Violence, Part 2:

Amy Barnhorst, MD, Vice Chair for Community Mental Health, Department of Psychiatry, UC Davis. Director, The BulletPoints Project; Associate Director, California Firearm Violence Research Center; "***Reducing Firearm Injury & Death: What Clinicians Can Do."***

a. Dr. Barnhorst runs the BulletPoints Project, funded by the State of California thru the Firearm and Violence Research Center at Davis. The goal of BulletPoints is to teach clinicians how to identify patients at risk for firearm injury, how to open conversations with them, and how to intervene appropriately for their type and level of risk. Due to the Covid-19 pandemic they ended up making material available online and is readily available.

b. Firearm injury is a public health program and most physicians surveyed say they do think it is within their clinical responsibilities, much like cigarette smoking, bike helmets, seat belts. And most patients generally agree it is important.

b.1. Barriers physicians cite include not knowing who would be at risk, what to do if they found a person at-risk had a gun and not thinking there is an intervention they (physicians) could employ.

b.2. Putting safety between suicidality and someone with firearms is one of the most evidence-based interventions so it is important that physicians who see patients at risk for suicide are familiar with this.

b.3. Americans make up 4.25% of world's population but own 46% of privately owned firearms. Rates of firearm injury and death are much higher than any other country.

b.4. The BulletPoints Objectives include:

b.4.a. Identify risk for firearm-related harm and ways to engage with patients to reduce that risk.

b.4.b. Understand how to have culturally appropriate and respectful conversations with patients and families to reduce risk.

b.4.b.1. This is important, as those who are the most risk of injury are firearm owners. If we alienate gun owners in our conversations about gun programs we will lose our audience, they won't engage, and it becomes another polarizing topic in the American discourse.

b.4.c. Describe available interventions for patients at risk for firearm-related harm.

b.5. The Curriculum objectives include:

b.5.a. Assess risk and talk with patients about risk and access to firearms when it is clinically relevant.

b.5.a.1. They do not necessarily endorse universal screening because there are a lot of things people already get screened for.

b.5.a.2. She recommend that clinicians be able to recognize those who are at risk and then have a more in-depth meaningful conversation about that risk.

b.5.b. Use 3 A's Framework to assess risk, Approach, Assess, Act:

b.5.b.1. A: Approach:

b.5.b.1.i. Be Informed: understand who owns guns and why, be aware of implicit bias; know safe ways to store guns and appropriate recommendations, be aware of relevant policies in your area. Use appropriate language avoiding alarmist language such as 'reducing access' (rather than 'get rid of

all guns), 'temporary' (vs permanent gun removal), 'during time of crisis or risk' and when possible, 'voluntary and collaborative'.

b.5.b.1.ii. Be Respectful: keep personal politics out of the conversation, keep the focus on risk and safety rather than right or wrong.

b.5.b.1.iii. Focus on Harm Reduction: reducing risk is better than a recommendation that would eliminate risk but would not be followed.

b.5.b.1.iv. Individualize your approach: who is at risk, who is in the home, what type of risk, reason for ownership.

b.5.b.2.A: Assess:

b.5.b.2.i. Risk factors: 3 main categories:

b.5.b.2.i.a. Demographics; for example, older white males at higher risk for suicide, younger black males at higher risk for homicide.

b.5.b.2.i.b. Individual risk factors: prior suicidal ideations or violence, substance misuse, serious mental health illness (risk for violence and suicide), substance misuse, dementia or cognitive impairment, abusive partners, recent relationship, or job loss.

b.5.b.2.i.c. Dr. Barnhorst showed a video example on approaching a patient discussion. The video is in a module at bulletpointsproject.org.

b.5.b.3.A: Act: (once you assess the situation, can collaborate with the patient to develop a plan)

b.5.b.3.i. Safe Storage (least restrictive)

b.5.b.3.i.a. If no one is at imminent risk, safe storage is the appropriate recommendation. A video on safe storage was shared. This (and other related videos) can be found on the BulletPoints website for reference.

b.5.b.3.ii. Temporary Transfer: used when removing firearms from home is safest option and the person is willing to collaborate.

b.5.b.3.ii.a. Temporary transfer to family or another trusted person.

b.5.b.3.ii.b. Background check requirement vary (not required in California if person is at risk of suicide)

b.5.b.3.ii.c. Some gun shops, ranges, and law enforcement are willing to store guns.

b.5.b.3.ii.d. Policies are in flux in some places.

b.5.b.3.iii. Mental Health Hold (mental health old or protection order are more extreme measures that may be necessary if a person is unable or unwilling to collaborate but at risk; these methods are not mutually exclusive)

b.5.b.3.iii.a. In California a "5150" allows, in emergency situations, if someone is at risk of harming themselves or others that mental health holds can bring them into treatment.

b.5.b.3.iii.a.1) An emergency mental health hold or even a hospitalization does not guarantee a person won't have continues firearm access. (this is where a gun violence restraining order can come into play)

b.5.b.3.iii.a.2) Federal firearm prohibitions do not occur until a person is committed in court.

b.5.b.3.iv. Civil Protective Order (Gun Violence Restraining Order, GVRO, is in this category; these are more limiting and extreme interventions)

b.5.b.3.iv.a. GVRO often passed in wake of mass shootings where the shooter may have had multiple red flags and was still able to purchase a firearm. The idea is it would allow for a family

member or someone else to petition the court to have their guns removed if there is significant danger in the future.

b.5.b.3.iv.b. In California petitioners include family and household members, law enforcement, school officials or teachers, employers or co-workers, dating partners or co-parents. This is modeled closely after the Domestic Violence Restraining Order (DVRO).

b.5.b.3.iv.c. In an emergency, law enforcement can get an order over the phone or family members and other petitioners can go to a judge, ex parte, meaning the respondent doesn't have any say in the situation.

b.5.b.3.iv.c.1) After 21 days, there is a hearing, and the respondent can defend themselves.

b.5.b.3.iv.c.2) Only about ½ of these orders go on to be long term restraining orders that prevent owning a gun for 1 to 5 years.

b.5.b.3.iv.c.3) ERPO's (emergency restraining protective orders) are currently in effect in 21 states and DC. All but 2 have been enacted since 2016.

b.5.b.3.iv.c.4) ERPO's have been an effective means to prevent suicide; For every 10-20 risk warrants issued for suicidality, one life is saved.

b.5.b.3.iv.d. In California, physicians cannot be petitioners, but we should be aware of these tools and can talk to law enforcement who file most of the enforcements.

b.5.c. The BulletPoints website provides information including various clinical scenarios with various groups at risk and provides epidemiology information. There are links to interventions appropriate to the types of risk. There is a page with information such as reasons for gun ownership as well as a page on structural determinants of violence. There is a 'guns 101' section and a resources tab that includes videos, podcase series and archived webinars. There are also 'explainer videos' and teaching materials. BulletPoints can be followed on social media and has a course that goes through 3 series of situations where firearms increase risk. The course is online, free, and available for CME. There is a large variety of resources for educators. This is a state supported curriculum, that included nearly 4 million dollars to develop curriculum and resources. For further information:

b.5.c.1. www.bulletpointsproject.org

b.5.c.2. Email: hs-bulletpoints@ucdavis.edu

b.5.c.3. X/Twitter: @BulletptsProj

b.6. Dr. Hattis opened up for Q&A and added he is considering a topic for a future forum meeting discussing patient health questionnaires for addressing environmental and social determinants of health. Patients often complete health history questionnaires that are scanned into the EHR but not asked about during the visit. He asked Amy if it would be appropriate to ask questions about gun violence on these types of screens

b.6.a. Amy stated there is a lot of back and forth on this topic. Amy personally is on the side of 'non-universal' screening because does not like being told that providers must do a lot of screens. She noted that patients respond better when the questions are asked in context rather than as part of a general screening. Screening can be very invasive if not asked in context. A general approach asking if a patient would like information may be useful.

V. Final Discussion:

a. Dr. Hattis inquired about discussion of screening, ways to address environmental and social determinants of health at a future meeting. He requested any suggestions can be emailed to him at preventivemed@aol.com

b. Cynthia shared information called Thrive Thru Civic Health: We Will Vote, a new non-partisan voting initiative led by coalition of civic and health groups including the American Public Health Association, Civic Health Alliance, Vote ER. She notes there are 2 main reasons why it is necessary:

b.1. The correlation between civic engagement, voting, and health is strong. The AMA has recognized voting as an important social determinant of health (SDOH) and HHS made voter participation a key metric for healthy people 2030.

b.2. Health is always on the ballot, whether you care most about climate health, reproductive rights, or gun safety. We need to help get out the vote for health. This initiative is aimed at helping health professionals to vote and then get institutional involvement to help others vote.

b.3. An estimated 8 million did not vote in the general election and 13 million in the midterm elections. Cynthia said that when we look at the issues we care about, and as public health people, we know it is the leaders and policies that drive low turnout, which is a huge, missed opportunity.

b.4. They have been working to include voting as part of a SDOH screen and EPIC may be working to incorporate it into the EHR but maybe we also need to make sure we are voting ourselves.

b.4.a. Webinar put out by National Academy of Sciences, and she will send the links and information to Ron to share with others.

b.4.b. Cynthia would like to hear from others who are interested in further information and resources.

b.4.c. She included this link in chat: https://tally.so/r/3xY2dG

b.5. They are also working with medical students for a sustainable future and climate resources for health education in a model similar to what Don Winslow is working on in terms of incorporating modules that medical schools can integrate into their curriculum for climate but also civic engagement as a main advocacy tool.

b.6. Ron discussed utilizing screens to detect determinants of health in a time-efficient manner. Cynthia noted groups are achieving this by incorporating questions such as voting into the social history. In Santa Clara it is incorporated into the pre-questionnaire. This can be covered in 15 seconds if it is built into the system and becomes routine. Ron added that environmental determinants are often overlooked yet important and he is pushing for more attention to them during clinical visits.

c. The meeting was officially concluded at 9:48 am.

Submitted by Traci Stevenson, Secretary, with edits by Ron Hattis
Approved at meeting of Jun 11, 2024