Dr. Garen Wintemute – Director of the Violence Prevention Research Program

Mark Masselli: This is Conversation on Healthcare, I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Well, Margaret, another week another mass shooting and this time the target of gun violence was a group of Congressional Republicans gathered for a practice before the annual Congressional Baseball game. Five were wounded including Louisiana Congressman Steve Scalise, who suffered critical injuries as a result of the shooting. Capitol Police were able to bring down the suspect, but it was yet another shocking example of how prevalent such gun violence has become.

Margaret Flinter: And you know the shocking news here is also that there have been more than 155 mass shootings across the country in just the past year, Mark. Gun violence is now the third leading cause of death for American children. Some 33,000 deaths by gun occur in this country every year. We often tend to focus on the mass shootings that grab the headlines but the problem is much more pervasive than that Mark, this is a Public Health Emergency.

Mark Masselli: Well the majority of Americans feel we should have stricter gun laws in this country. The policymakers seem to be taking things in the opposite direction. We often see an take in lip service to the victims of gun violence after episodes like this, but not enough to engender support for new policy directors that might curb the sale of guns in this country, especially the most deadly assault weapons, but background check still are not mandatory in all states.

Margaret Flinter: Well, Mark this most recent incident brought to mind, a memorable guest we have on the show, in the past year, Dr. Garen Wintemute is an Emergency Medicine Physician and Professor at UC Davis. He is also the founder and director of the Violence Prevention Research Institute where he has been studying the depth and the scope of the gun violence epidemic in this country for more than 20 years. Some of the policies that have led to these high numbers and the impact its had on population health.

Mark Masselli: We will also be joined by Lori Robertson, the Managing Editor of Factcheck.org, who is always on the hunt for misstatement spoken about health policy in the public domain.

Margaret Flinter: And no matter what the topic you can hear all of our shows by going to www.chcradio.com and as always if you have comments, please email us at www.chcradio@chc1.com or find us on Facebook or Twitter because we would love to hear from you. Now we will get you our interview with Dr. Garen Wintemute, in just a moment.

Mark Masselli: But first, here is our producer Marianne O'Hare with this week's Headline News.

Dr. Garen Wintemute – Director of the Violence Prevention Research Program

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Marianne O'Hare: I am Marianne O'Hare with these Healthcare Headlines. The Republican Healthcare building crafted behind closed doors in a Senate is starting to see the light of day being by called by one lawmaker on the inside is an iterative process. The American Health Care Act which narrowly passed in the House is under reconstruction in the GOP-controlled Senate. The Majority Leader Mitch McConnell wants a vote on the revised bill before the July 4th summer recess. Insiders in the know are saying a number of measures that are likely to remain and roll back of the Medicaid expansion, caps on Medicaid grants to states. And loss of essential benefits that are required to be cover by all insurance companies, also the loss of protections for older secure Americans.

The nonpartisan Congressional Budget Office will have little time to score the Senate version of the bill. And there will not likely be any time for our committee input or any input at all from Democrats in the Senate. Many of those on Medicaid are receiving recovery treatment for opioid addiction. Now many are worried about the Republican focus on rolling back Medicaid and the fact that it may destroy their ongoing success with medication assisted drug treatment. Saying they wouldn't be able to afford the monthly drug treatment on their own.

As the death toll arises from the opioid addiction crisis, several communities across the country are considering sanctioning legal injection sites for opioid users, to shoot up under supervision with clean needles. An estimated 50,000 people died from opioid overdose last year. States like Indiana saw a huge spike in HIV and Hepatitis C infections among opioid addicts who were sharing needles, setting them up for a highly, costly cure in the case of Hep C or a lifetime of medication control in the case of HIV.

The California Legislature is considering a bill that would authorize eight California counties to test so called safe injection sites. Addiction experts see this as an excellent opportunity to monitor chronic opioid users, reduce their risk of overdose or disease transmission through shared hypodermic needles and provide a safe interface to lead addicts to treatment. Opponents view this as giving addicts a "green light" to continue abusing drugs.

Currently Vancouver, Canada is the only region in North America where such a program has been underway for several years now. And the data are promising for improving outcomes. Study published in The Lancet found that overdose deaths on the street surrounding Vancouver's safe injection site dropped 35% in the two years after it opened. The sponsor of a California Bill says, the "safe injection sites" would operate more like medical clinics ensuring that drug abuse counselors are on hand to offer guidance towards drug treatment options as well as being armed with naloxone for those who experience an overdose.

Blood poisoning of children has gained significant coverage in recent years on the yields of the Flint water crisis where state officials switched the cities drinking water source and denied for many months the toxic new water supply unleashed significant amounts of lead into the drinking water. Now a study out shows an estimated 29 California communities have a lead poisoning levels surpassing the numbers in Flint. The city of Fresno, California has three times the rate of lead poisoning. Poverty and poor housing are being sited, by the exclusive Reuters Report for those high rates of lead poisoning.

And because children's brain are so vulnerable to any exposure at all to lead, an independent study of popular baby food shows 20% of that prepared jarred foods for babies and toddlers had some level of lead in them. The highest concentration was in apple and grape juice as well as sweet potatoes and carrots. The report issued by the Environmental Defense Fund examined data released by the EPA. According to the data it seems prepared baby foods are the single biggest contributor to lead exposure in children. Even a few micrograms per day can cause permanent brain damage and attention deficit in children.

And speaking of ADHD, a drug company Shire has been given FDA approval for a long-acting drug to treat attention deficit disorder in teens and adults. Shire whose ADHD drugs Adderrall and Vyvanse generated close to $2.4 billion in sales last year alone, plans to launch Mydayis. A recent data show up to 11% of American children are afflicted and more than half continue to suffer as adults. Both Mydayis and Adderall XR contain amphetamine, as stimulant that elevates levels of dopamine, a neurotransmitter associated with motivation, attention and movement. And such drugs carry a risk of abuse, even fatal in rare cases. Non-stimulatant ADHD treatments have fewer side-effects but are typically less effective. I am Marianne O'Hare with these Healthcare Headlines.

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Mark Masselli: We are speaking today with Dr. Garen Wintemute, Director of the Violence Prevention Research Institute at the University of California Davis, an ER physician and professor of Emergency Medicine, Dr. Wintemute is also a leading global researcher on analyzing gun violence from a public health perspective. He served as medical coordinator at the Nong Samet Refugee Camp in Cambodia. He earned his undergraduate degree at Yale. His has Masters in Public Health at John's Hopkins and earned his medical degree and did his residency at UC Davis. Dr. Wintemute, thank you for joining us at Conversations on Healthcare Today.

Dr. Garen Wintemute: Thanks for having me.

Mark Masselli: You launched after your ER experience the Violence Protection Research Program at UC Davis, back in 1980s and sort of kudos to you for being

a pioneer. And I am wondering if you could take our listeners back to the sort of the driving mission of the work that you do at the Violence Protection Research Program and maybe any seminal moment experienced that brought you to spend a lifetime engaged in this work.

Dr. Garen Wintemute: We, for some years have used Emergency Departments and Trauma Services here in the U.S. to train the armed services combat surgical teams because they can see battlefield trauma right here in the United States. Back in the 80s and early 90s, it was actually something of a hard sell that violence was a health problem and not a crime problem. And the best encapsulation of the argument I have ever heard came from David Satcher, a physician who had just taken over at CDC and was asked about this and he said, "Look, if violence isn't a health problem than why are all these people dying from it." In my own case, the experience was at that time in Cambodia that you mentioned. It was a very intensive experience in the power of violence to disrupt people's lives, not long after I got home realized I can do that work right here.

And the other realization, the vast majority of people who die from gunshot wounds in the United States, die where they are shot. It doesn't matter how fast the ambulance is, it doesn't matter how good the ER docs and the surgeons are those people are just dead. And for me and others, there came the recognition that if we ask clinicians want to make the maximum inroad into the number of people, who die from firearm violence, we need to prevent them from being shot in the first place.

Margaret Flinter: Oh yeah, Dr. Wintemute, I am not sure our listeners would be very familiar with the Dickey Amendment, which Congress passed 20 years ago, which essentially barred the Centers for Disease Control from utilizing any government funds for research that might somehow support gun control legislation. Help our listeners understand what was this Dickey Amendment and the impact it had on your research or the research of your colleagues. I understand that you have basically began to contribute your own personal funds to keep this vital work going, tell us about that?

Dr. Garen Wintemute: So in the early 1990s, we were facing a real epidemic of firearm violence. And the country did what we do best and should be very proud of, we committed funding to understanding the problem better. Congress was interested in doing something with the results of the research. It is sort of like the mobilizations that we have had for cancer and heart disease and motor vehicle injuries. We are doing it now for opioid abuse and then the Zika virus. The difference is that that mobilization was choked off. There were and are interests in the United States who oppose changes in firearm policy. And I think they took the position that let's simply choke off the supply of the evidence that might make those changes possible.

Jay Dickey was a Congressman from Arkansas, describing himself as the appoint person for the National Rifle Association, carried an amendment that was adopted by Congress and that said that federal funds could not be used “to advocate or promote gun control.” Congress took from CDC’s budget this is the mid-1990s, took from the CDC’s budget the amount of money that they had been spending on firearm research. And gave it back to them year marked for another purpose, CDC’s overnight within a few months, shutdown their extramural funding program. We had a research program going in large part with their support and CDC still does not fund research. Other federal agencies do, the National Institute of Justice, I think NIH but for criminal justice matters. And a few years ago, the National Institutes of Health launched for the first time in their history, a program of funding for research on firearm violence.

Compared to what’s needed, it falls way, way short. The question that I have is as both a researcher and a clinician, is how many thousands of people are dead today, who would be alive, if that work had been allowed to continue. If we had been able to enact policies based on the answers to tough questions, when today, we don’t have those questions answered.

Mark Masselli: Well that there were 34,000 gun related deaths per year in this country, it’s about a 100 a day. Excited to do a controlled evaluation of that California Armed and Prohibited Persons System which seeks to prevent violence by recovering firearms from persons who may have purchased them legally, but have since become prohibited persons, can you tell our listeners a little bit more about your findings?

Dr. Garen Wintemute: We work very hard in the United States to prevent prohibited people, felons people who have been convicted of domestic violence and so on from purchasing firearms. But we do essentially nothing when the reverse set of circumstances applies, when someone purchases a firearm legally and then at some time later, newly becomes a prohibited person. Here in California an effort is being undertaken, to address that gap. If a person has just had a prohibiting event occur and if they show up in that archive of firearm transactions, there is obviously a real possibility that they still possess a firearm and are prohibited from doing that.

What follows is a knock on the door and they are taken on a temporary basis, because those prohibitions might expire. What we know so far is that such a program is feasible and it can operate, it’s been operating for a while now. Thousands of firearms have been recovered; no one’s been hurt, nothing bad has happened. What we need to let sometime pass in order to determine, is whether the program works in the sense of reducing risk of future violence on the part of people who are affected and we are in the middle of that work right now.

Margaret Flinter: Well, that sort of leads us to the research that you have done, you know in primary care we routinely screen patients for the prevalence of

substance abuse. And we know that there is a corollary, particularly between alcohol and domestic violence. How did you analyze the connection between alcohol or substance abuse and gun violence and what did you find?

Dr. Garen Wintemute: There is a huge body of evidence establishing that alcohol abuse is a risk factor for future violence, by itself even when other risk factors are controlled for, specifically involving firearms. What there hasn't been, is a study of whether alcohol abuse is a risk factor for future violence, specifically among people who own firearms. And we have just actually finished one study in this area. And what we learned is that firearm owners are just like everybody else that even when you control for other risk factors for violence in the future, such as age and sex and a past history of violence. Alcohol abuse is a substantial and independent risk factor for future violence involving firearms, major violent crimes like homicide and rape and robbery and aggravated assault. The bottom-line is that we are learning that firearm owners aren't different; they are just like the rest of this when it comes to the relationship between alcohol and future violence.

Mark Masselli: We are speaking today with Dr. Garen Wintemute, Director of the Violence Prevention Research Institute at the University of California, Davis. Dr. Wintemute in the quest to understand the recent spate of mass shootings that have occurred around the country, the discussion often turns to the link between mental illness and gun violence. And what is your research revealed about the role of mental illness that are more likely to lead to gun violence?

Dr. Garen Wintemute: Well, no more than 4% to 5% of interpersonal violence can be directly attributed to serious mental illness by itself. There are certain points in the history of a mental illness when risk is increased, one is when that mental illness is first diagnosed, another is at times of acute exacerbation, when there has been a mental health emergency. And I want to draw a parallel here between mental illness and other chronic illnesses. Public mass shootings are a very, very small part of the overall problem of firearm violence in the United States. Well under 1% of fatalities from firearm violence in the United States come from mass shootings.

Margaret Flinter: Well one of the problems is just the unbelievable proliferation of weapon ownership in this country. And I understand that you have looked at the whole area of gun shows and gone to gun shows where private gun sales are a common occurrence, can you talk about this less regulated market place?

Dr. Garen Wintemute: We have fewer than 5% of the people on the planet. We have more than 40% of firearms in civilian hands. We have a set of policies that make the widest possible array of firearms available to the widest possible array of people for use. One such federal policy established what amounted two separate systems of commerce in firearms. If I buy a gun from a licensed retailer, I have to show my ID and fill out a very lengthy form and undergo a

background check. And the retailer has to keep a permanent record of the sale, which means I can be linked to the gun. But I can buy a gun from a private party and there is no paperwork, there is no background check, there is no waiting period. It's gun, cash and a handshake. And I the buyer get to choose which system I am going to use. If I am acquiring that gun with criminal intent and don't want anybody to know about it, that private party purchase is the only option for me. Nearly 40% of all firearm acquisitions in the United States occurs through that unregulated "don't ask, don't tell" system. And that proportion doubles from 40% to more than 80% if the firearm is being acquired with criminal intent.

Mark Masselli: You know you said a person can have a misdemeanor rap sheet as long as an arm and still be able to purchase a gun legally. Your research has shown that the most telling factor in predicting potential gun violence is the person's prevalence of petty crimes and misdemeanor convictions. So tell our listeners what your data has shown you about the connections between Lax gun laws and the incident of gun violence?

Dr. Garen Wintemute: So it is a myth that violent criminals cannot buy guns legally. A person under federal law can be convicted of any number of violent misdemeanors, assault and battery is a good example. Here in California, violent misdemeanants are not allowed to purchase firearms. And we evaluated that change in policy and found that it was quite effective. It reduced the risk of future violence in that population by 25% to 30%. We have got 50 laboratories in United States conducting experiments in firearm policy. And all these experiments are being conducted and there are very few people available to see what the results are.

Margaret Flinter: Dr. Wintemute, with so many guns in circulation curtailing the influence of the NRA isn't likely to happen anytime soon, certainly a very vocal contingent and Congress willing to hold the 24 hour incident demanding a more rational approach to gun policies. But I would like to ask you, what is your recommendation for the best way forward on getting the proper emphasis on the public health threat of gun violence?

Dr. Garen Wintemute: One is to get better evidence, at a time when policy reform might be in the offing, we need the best available evidence to guide those reforms. Here in California, the legislature authorized and the University of California is probably about to establish a Firearm Violence Research Center, that's a big problem in California as it is nationally, Congress hasn't stepped up, fair enough California will do its part. That measure was legislation, that was considered by the State Legislature and Jay Dickey wrote a very strong letter in support of that bill to establish a research center. Jay Dickey has had a change of heart and has recognized that his language which he spoke only to advocacy, had been used to suppress research and he has come to see that as wrong and it was very heartening to get his support.

I think that whatever the outcome of the election in November, there is going to be more support for research on this obvious large and pressing problem. I am optimistic having lived through the last three decades of this. I know the following to be true that the conversation has simply not stopped, since December of 2012, people have been talking without end and increasingly about how big a problem this is and how we need to do more about it. New people are signing up to help with the research effort, to help with the advocacy effort if that's where their skillset lies. I think we are not far away from seeing substantial change for the better.

Margaret Flinter: We have been speaking today with Dr. Garen Wintemute, Director of the Violence Prevention Research Institute at the University of California, at Davis. You can learn more about his work by going to www.ucdavis.edu/vprp, Dr. Wintemute, thank you so much for the very important work that you are doing and for joining us on Conversations on Healthcare Today.

Dr. Garen Wintemute: Sure, thanks very much for having me.

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Mark Masselli: At Conversations on Healthcare we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy, Lori Robertson is an award-winning journalist and Managing Editor of FactCheck.org, a non-partisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in U.S. politics. Lori, what have you got for us this week?

Lori Robertson: Opponents of the Republican Health Care Bill are claiming its provisions on preexisting conditions reached further than they actually do. For instance a TV ad from AARP says "insurers can charge thousands more" for preexisting conditions under the bill. They can, but that would happen only in states that obtained a waiver, and only for the relative few who buy policies on the individual marketplace and have a lapse in insurance coverage.

The House passed the American Health Care Act on May 4th and it is now under consideration by the Senate. The ad shows an accountant telling a man and a woman who both say they are over 50 years old, that insurance companies can charge them five times more because of their age. Under the Republican bill, insurers can charge older people five times more for premiums than younger people for insurance on the individual market. Insurers could even charge more than that under waivers that states could get under the bill.

The Affordable Care Act or Obamacare limits insurers to charging three times as much to older policyholders. But then the accountant in the ad asks, tells the couples that insurers can charge thousands more for preexisting conditions. The couple in the ad would have to meet several criteria for that to happen. Under

the House Republican bill, insurers cannot set premiums based on health status that's the case under the Affordable Care Act too. However, states can get a federal waiver to allow insurers to price policies on the individual market based on health status in some cases. Under the waiver, insurers could charge more for preexisting conditions if an individual hadn't maintained continuous coverage. That higher premium can be charged for one year, and then, provided there wasn't another 63-day lapse in coverage, the policyholder would get a new premium that wasn't based on health status.

The Kaiser Family Foundation estimates 7% of the population had insurance on the individual market in 2015. And AARP estimated this year that 6 million people aged 50 to 64 got individual market insurance. Democratic Senator Catherine Cortez Masto also wrongly claimed that more than 1.2 million people with preexisting conditions in her state of Nevada "would be denied coverage or face exorbitant, unaffordable premiums." The bill doesn't allow insurers to deny coverage and her figure is a high end estimates for all Nevadans with some preexisting conditions. 7% of Nevadans get coverage through that market while 46% of the state's population has employer-sponsored coverage. And that's my factcheck for this week; I am Lori Robertson, Managing Editor of Factcheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact that you would like checked, email us at www.chcradio.com, we will have FactCheck.org's, Lori Robertson, check it out for you, here on Conversations on Healthcare.

Margaret Flinter: Each week conversations highlights a bright idea about how to make wellness a part of our communities in everyday lives. Of the roughly 4 million women who gave birth annually in the United States, a quarter of them retain at least 10 pounds gained during their pregnancy. Now these women are also more likely to add weight during the first postpartum year. Those numbers go up significantly for African American, Hispanic and low-income women.

Dr. Suzanne Phelan: So I was interested in finding way to help women during their time, because regardless of how much a woman gains during pregnancy, weight gained during this period is that kind of independent risk factor, we call it.

Margaret Flinter: California Polytechnic Institute researcher Dr. Suzanne Phelan wondered, if a customized intervention designed around the supplements or nutrition program for women as well as the Women, Infants and Children Nutrition Program, might help such women shed postpartum weight.

Dr. Suzanne Phelan: You see about 30% dropout and there is no surprise those women during the postpartum period, they are busy with their baby, they have got this erratic unpredictable schedule. And so our team got together and we thought, you know let's try something online.

Margaret Flinter: Her team designed a website with feature such as weekly lessons, a web diary, instructional videos, computerized feedback, text messages and monthly face-to-face groups at the WIC clinics. Twelve clinics were randomized to the WIC program or the standard care group or the WIC program plus the 12-month primarily internet-based weight loss program.

Dr. Suzanne Phelan: Yeah so the intervention targeted healthy eating and physical activity and then behavioral strategies. And so we provided some menu plans online that would promote modest weight-loss and we gave them calorie goals dependent on if they were breast-feeding or not and we also gave them physical activity goals which were 30-minutes most days of the week. And we gave behavioral tools too, including self-monitoring, daily recording of their food and take --.

Margaret Flinter: And the results were significant. More women with the internet intervention, 57% lost weight than the WIC participants alone?

Dr. Suzanne Phelan: Not only that they got weight-loss and we got a greater proportion of women who lost the 5% and 10% of their body weight which we know are clinically significance and they reduce their waist circumference which is a health indicator for long-term health risk, but the women retained weight differentially around the waist in the postpartum period. So it was exciting that we prevented that and even reduced waist circumference.

Margaret Flinter: The loss translates into a statistically lower risk of later weight gain and the long-term risk for related health issues such as diabetes and heart disease that accompany it.

Dr. Suzanne Phelan: So the other key finding is, we got a greater percentage of women returned to their prepregnancy weights. The fact that we got them back to their prepregnancy weight is really exciting because you retain weight above prepregnancy that's the risk factor for long-term health problems.

Margaret Flinter: A low cost, guided online nutrition on weight-loss support program designed for women receiving snap and quick benefits for postpartum nutrition, empowering them additional tools to lose that nagging baby weight, so many women struggle with. And yielding a greater weight-loss success and healthier outcomes, now that's a bright idea.

Margaret Flinter: This is Conversations on Healthcare, I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

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