Medical Directors Newsletter
January 2020

Addressing Structural Urbanism

"Current models of health care funding, which treat health care as a service for an individual rather than as infrastructure for a population, are innately biased in favor of large populations."

--Janice Probst, Jan Marie Eberth, and Elizabeth Crouch in *Health Affairs*, December, 2019

In January 2019, the California Department of Health Care Services (DHCS) decided that all providers that contract with PHC, and other Medi-Cal Managed Care Plans, must apply to the state and be accepted as official Medi-Cal providers. Previously, PHC could contract with specialists in Oregon and Nevada who are closer to our members who live in border counties. These specialists are excellent physicians to partner with and are recognized by Medicare and the state Medicaid organizations in which they practiced. The DHCS decision was not required by the federal government, it was a based on administrative convenience. The needs of MediCal beneficiaries in border regions were not considered sufficient to alter the policy.

This is an example of Structural Urbanism.

In their article in Health Affairs from December 2019, titled, *Structural Urbanism Contributes to Poorer Health Outcomes for Rural America*, the authors define Structural Urbanism as "elements of the current public health and health care systems that disadvantage rural communities."

This can include policies and regulations, like the rule on out-of-state specialists noted above.

It can also include the fee-for-service payment methodology, which pays hospitals based on volume: smaller rural hospitals have far more fixed costs per admission, so an "equal" payment arrangement disadvantages smaller rural hospitals, contributing to financial instability and hospital closures. This is another example of Structural Urbanism.

It can also extend to state grant programs, like the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program designating payments to public hospitals, which are all situated in counties with large urban populations. While some version may be adapted to smaller counties, at best only medium-sized counties have the infrastructure to access these funds. This is yet another example of Structural Urbanism.

Structural Urbanism impacts county social services infrastructure which, in turn affects health status.

Structural Urbanism affects primary care access. National Health Service Corps loan repayment eligibility is dependent on the Health Professional Shortage Area score (HPSA score), which supposedly measures the relative need for physicians in a particular area. The score in parts of urban LA County is higher than many rural areas in Northern California. While urban health centers serving poor areas need providers, the providers are able to commute from areas that are more affluent. In contrast, rural California Health Centers need to convince new clinicians to move to a new area. The scoring methodology does not account for this, which is another example of Structural Urbanism.

Decades ago, sociologists coined the term "Structural Racism" to describe the historic, political and social structures that perpetuate racial inequality. Structural Racism is partly responsible for poorer health outcomes for marginalized racial and ethnic groups.

Resistance to the Structural Racism framework is manifested by attribution of persistent inequalities to choices made by individuals, assuming that all barriers can be overcome with sufficient self-motivation.

There is a conceptual similarity between Structural Racism and Structural Urbanism. Health outcomes in rural populations have complex and inter-related structural factors. Are poorer outcomes due to the “choice” to live in rural areas? Are they due to poverty itself? If so, why do poor populations in urban and suburban areas have better outcomes than poor populations in rural areas? How do differential access to social services, philanthropy and health care providers, which are associated with rural areas, contribute to differential outcomes? These many factors are the manifestations of Structural Urbanism.

We can measure worse health outcomes in rural counties. Each year, after conducting our annual audit of the Health Effectiveness Data Information Set (HEDIS), we stratify the results based on the demographic information we have available. Specifically, we are looking for different outcomes that are associated with any particular race/ethnic or language group and geography. Since 2014, we have found that outcomes vary more by geography more than by any particular race/ethnic or language group.

Outcomes have improved slightly year over year, but the geographic disparities remain: in 2018 the nine northern rural counties have composite quality scores ranging from 14 to 32 out of 84 possible points, far below those in the more urban/suburban southern five counties, which range from 53 to 59 out of 84 points.

How do we achieve better outcomes for rural counties? How do we overcome Structural Urbanism? The Health Affairs review article mentioned above has several recommendations:

1. **Access.** Maintain and increase availability of health care providers and institutions in rural areas.
2. **Conceptualization.** Change the conception of the provision of health in rural areas from being a *service* to being *infrastructure*. Decades ago, rural hospitals were funded by the federal government as infrastructure and were able to grow and thrive. Since the conversion to a fee-for-service environment, rural hospitals are closing and quality measures for rural hospitals (which previously were equal to urban hospitals, in aggregate) have steadily declined.
3. **Resources.** Additional financial resources can help reduce rural inequities. The National Health Service in England created such a financial redistribution method in the 1970s and 1980s to provide additional resources to rural areas, resulting in decreased access disparities from 22% to 6% in a 12-year period.

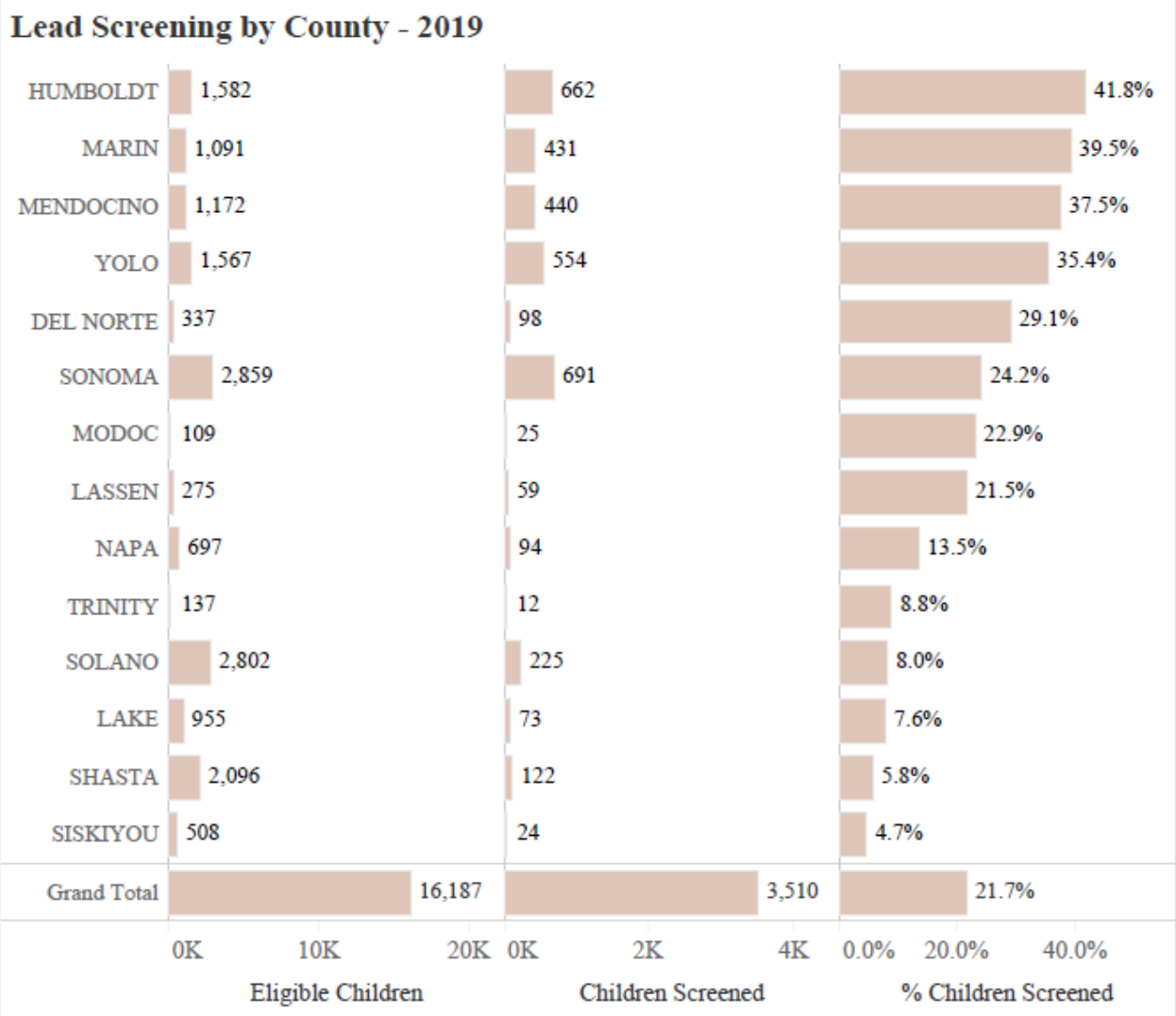
Partnership Health Plan is dedicated to addressing Structural Urbanism at multiple levels: interventions to increase provider access, leveraging funding mechanisms to provide differential support of rural health care providers, addressing social issues which impact health (like housing instability, substance use, and post-incarceration status).

Correcting many other contributors to Structural Urbanism will require legislative and regulatory changes at the state and federal levels. Defining a prioritized policy agenda will require us to work together with our partners in rural areas.

Acting on a rural policy agenda is challenging, as organizations working in rural areas have less staff time available to do advocacy compared to urban organizations. Yet another manifestation of Structural Urbanism!

Pediatric Lead Testing

Earlier this month, the California State Auditor issued a report criticizing the California Department of Health Care Services (DHCS) for allowing many children, with Medi-Cal, to miss their blood lead level screening at age one and two, as recommended by the Centers for Disease Control (CDC) and required by federal, state and PHC policy. The rate of lead testing varies widely across the PHC region, as noted on this graph:



Even small elevations of blood lead are associated with negative cognitive effects; the CDC considers levels greater than 5 mcg/dl abnormal in children, worthy of intervention and re-testing. Resources for clinicians can be found at the CDPH website: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/CLPPB/Pages/prov.aspx

We ask that you ensure your providers understand the current recommendations around lead testing, and that reminders to order a blood test are built into you templates for one year old and two year old children. If you think the data above don't reflect the level of testing being done, we recommend doing a spot audit of billing processes to be sure claims are being submitted when lead testing is being done.

Breaking News

New Codes for Health Behavior Assessment and Intervention

The CPT codes for mental health counseling focused on improving self-management and coping with medical conditions (like hypertension, asthma or diabetes) changed effective January 2020. These are billed by the primary care provider to PHC (not through Beacon), although they may be performed by office staff members trained to provide such counseling.

The range of new codes is 96156 - 96171. The old codes (no longer valid) are: 96150-96155.

Counseling may be in an individual, family or group setting – the codes vary by setting; see the 2020 CPT manual for details.

Non-physician Clinicians invited to participate on PHC's Advisory Committees

Clinician input into PHC's health policies is a pillar of our structure as a community-responsive, County Organized Health System. Several of our committees include clinician members: Board of Commissioners, Physician Advisory Committee, Quality Utilization Advisory Committee (all open to the public), as well as the Pharmacy and Therapeutics Committee, Credentials Committee and Peer Review Committee (closed to the public).

All these committees are open to both physician and non-physician clinicians: Nurse Practitioners, Physician Assistants, Nurse Midwives, and Pharmacists. Participating on a PHC policy committee is a leadership growth opportunity for emerging leaders.

If you or someone in your organization is interested in joining a PHC policy committee, please reach out to your local PHC regional medical director to discuss attending a committee meeting as a guest, to get a sense of what is involved:

- David Glossbrenner, MD, Northern Regional Medical Director, Trinity, Shasta, Siskiyou, Modoc and Lassen Counties
- Jeff Ribordy, MD, Regional Medical Director, Humboldt and Del Norte Counties
- Marshall Kubota, MD, Regional Medical Director, Marin, Sonoma, Mendocino and Lake Counties
- Colleen Townsend, MD, Regional Medical Director, Napa, Solano and Yolo Counties

PHC Educational Opportunities and Events

Regional Medical Directors Meetings: Save the Date

PHC hosts four regional in-person meetings with clinical leaders of primary care organizations about twice a year. Please save the dates of our upcoming meetings. More details will be shared in future newsletters.

- April 17, 2020 - Redding (9 a.m. to 3 p.m.)
- April 24, 2020 - Eureka (9 a.m. to 3 p.m.)
- May 1, 2020 - Ukiah (9 a.m. to 3 p.m.)
- May 8, 2020 - Novato (9 a.m. to 3 p.m.)

ABCs of Quality Improvement

At this free, all-day training, participants will be introduced to the Model for Improvement, learn how to develop AIM statements, measures and PDSA cycles, and will learn how to use data for quality improvement.

Who should attend? QI clinical champions (providers and nurses), clinic managers, QI staff or project leads, and front and back office staff are encouraged to attend.

Date: March 11, 2020
Time: 8 a.m. - 4:30 p.m.
Location: Hyatt Regency Sonoma Wine Country - Santa Rosa, CA
Registration: click here

Date: April 16, 2020
Time: 9 a.m. – 4:30 p.m.
Location: The McConnell Foundation Lema Ranch – Redding, CA
Registration: click here
Flyer

Recommended Educational Opportunities Outside of PHC

Webinar, Unbefriended and Unrepresented: Medical Decision Making for the Incapacitated and Alone

Patients who have lost capacity to make medical decisions and who have no readily identifiable surrogate decision-maker are known as "unrepresented" (sometimes referred to as "unbefriended") patients. Estimates range from 5% of Intensive Care Unit (ICU) deaths and 3-4% of long-term care residents are unrepresented.

These cases raise clinical, ethical and legal questions about who should make decisions for these patients. The unrepresented may eventually fall into the purview of a public guardian or conservator. However, in most jurisdictions, this is a time-consuming, expensive, and resource-limited option that is ill-suited for complex and often urgent treatment decisions.

This webinar will offer clinicians an approach to managing the growing epidemic of unrepresented older adults with a goal of ensuring that treatments are concordant with their preferences, values and best interests.

Webinar participants will be able to:

- Review the epidemiology of unrepresented older adults and how decisions are currently being made for these individuals.
- Discuss ways to decrease the risk of older adults from becoming unrepresented.
- Provide a clinical, ethical and legal framework for decision-making in unrepresented situations across the continuum of care, including hospital, long-term care, assisted living and hospice settings.
- Share institutional mechanisms to ensure that adequate safeguards are in place to protect this vulnerable population, including a novel program developed using volunteer advocates.

Date: February 4, 2020
Time: 12 p.m. – 1 p.m.
Cost: Standard Registration, $99.00
Registration: click here

Eating Disorders 101 - Prevention and Screening Webinar

The majority of those who struggle with Eating Disorders (EDs) never receive treatment, even though effective treatments for a range of eating disorders are well established (National Institute of Mental Health). There is a need to train primary care and behavioral health providers on how to recognize the signs and symptoms of eating disorders in children, adolescents, and young adults; and to appropriately screen, intervene and treat or refer patients to specialized care in an integrated setting.

This training series will be in collaboration with the National Center of Excellence for Eating Disorders (NCEED), an organization founded in 2018 by the Substance Abuse and Mental Health Services Administration. The goal of this webinar series is to increase health center capacity to detect and treat eating disorders and to increase public knowledge and awareness of these illnesses. This webinar series will address both adolescent and adult populations and address co-occurring diagnoses with eating disorders, mental health and substance use disorder.

Event Information & Registration: Click Here

Webinar 2: The Role of Primary Care in Treating Eating Disorders
Date: February 6, 2020
Time: 1 p.m. to 2 p.m.

Webinar 3: The Role of Behavioral Health in Treating Eating Disorders
Date: February 20, 2020
Time: 1 p.m. to 2 p.m.

Webinar 4: Addressing Systemic Care Coordination between Health Plans
Date: March 5, 2020
Time: 1 p.m. to 2 p.m.