Medical Directors Newsletter
June 2020

"I am only one; but still I am one. I cannot do everything; but still I can do something; and because I cannot do everything, I will not refuse to do the something that I can do."

--Edward Everett Hall, 19th century American social activist

Translating Black Lives Matter to Health Care

We at Partnership HealthPlan of California (PHC) are deeply saddened by the recent killings of George Floyd and many other Black Americans. Further, we recognize that systemic and historic racism remains the core cause of this violence.

As respected clinicians, we acknowledge that you are participating and advocating to address local policing practices. Additionally, we know you are involved in the broader community dialogue to address underlying causes of bias and discrimination, which disproportionately affect the Black members of our communities. Through your actions, you are also helping many other disenfranchised populations.

In the health care community, we are generally not part of a police force and think of our caring profession as one that serves everyone regardless of race, ethnicity, sexual orientation, gender identification, incarceration status, religion, disability, etc. However, there is a deep history of racial injustice in health care in our country ranging from early experiments in gynecological surgery done on American slave women, to the infamous Tuskegee study of the natural history of tertiary syphilis, which withheld curative penicillin from Black American men to document the progressive neurological symptoms of this curable disease.

Implicit and explicit bias is still present and impacts the health and well-being of all the patients we have taken an oath to serve as health care professionals. An example of the consequences of bias impacting Black Americans in healthcare today is the differential evaluation of pain symptoms of pregnant Black women in California, causing delay in diagnosis of serious complications and contributing to a maternal mortality rate in California that is three times the rate of all other ethnic groups.

These biases are more commonly manifested in less tragic ways and is found in the way non-white patients are treated by doctors, nurses and others within the healthcare delivery system. As an example, many years ago, a Latino nurse at a health center where I worked was injured when he worked on his car-- the engine fell on his chest. He arrived to the ED in his grease-stained work clothes and pain in his chest. The ED nurses who cared for him did not know that he was nurse. While he was in their care, they were making comments, using body language and words that lacked compassion and respect, and withheld pain medication. The physician progress note referred to him as "greasy Mexican" in his chief complaint statement. He indeed had motor oil on his clothes and skin.

On a broader level, physical conditions are the manifestations of the environment/ social conditions in which your patients live in and carry with them when they seek care. When a significant portion of the patient population feels dismissed,

disenfranchised or discarded, *doing no harm* then has to stretch beyond the mere facts and symptoms you see and face in the few minutes you have with your patients. Instead, we must strive toward mindful and thoughtful consideration of a world in which our patients dwell.

We must take action to initiate changes within our health care delivery system to parallel to actions being carried out by our society to ameliorate the effects of bias and to decrease institutional racism that afflicts our patients and communities.

On an individual level, both in the health care arena and the broader societal arena, we need to have thoughtful and meaningful dialogue with:

1. Ourselves
2. Our friends
3. Strangers

The rationale and tactics are different for each of these levels of dialogue.

Ourselves. The first level, dialogue with ourselves, is another way of describing introspection, where we seek to understand our own implicit biases and address them. This can be done by reading one of many excellent books on this topic like *Thinking Fast and Slow*, *How to be an Antiracist* and *White Fragility*, by enrolling in a class or community discussion group on racism, and by writing and reflecting about how the ideas in these books and groups affect you. Changing the brain pathways that cause implicit bias takes time and effort; we need to make it a life-long personal self-educational priority.

Our Friends. As we are better able to understand our values and biases, we are in a position to use this insight to influence those we interact with every day: friends, family, and co-workers (including those with a different set of political beliefs). Being an activist against bullying behavior and violence is especially important for addressing abuses in use of force and underlying policies promoting or allowing such abuses. However, influencing other people's thinking in order to foster their better understanding of their own biases requires different and individualized approaches. This might mean responding to a gratuitous racial generalization with disagreement and a reflection of how it makes us feel. More subtle cases may be better addressed in a dialogue to promote introspection: "What did you mean by that?" or "What makes you think that?" A more round-about way of changing beliefs is through skillful storytelling, tapping into the human brain's built-in capacity to absorb new values. Collecting a repertoire of stories to use requires being alert to examples in our everyday lives, and recording and using stories we hear from other sources.

Strangers. As clinicians, we frequently meet with new patients with very different racial, ethnic, religious, nationality, etc. backgrounds. These interactions may go very wrong, with lack of trust in the clinician, incorrect diagnoses, poor adherence to clinician recommendation, and general dissatisfaction by the patient. Each day PHC receives member complaints of poor communication or possible discrimination. These are a reflection of suboptimal interaction with patients.

While many clinicians are experts at developing trust with their patients, others struggle and would benefit from training and mentoring, something not widely available after residency. In the January 7 issue of JAMA, an expert panel identified 5 elements of high quality patient interaction:

1. Prepare with intention
2. Listen intently and completely
3. Agree on what matters most
4. Connect with the patient's story
5. Explore emotional cues

Recently, resident physicians from across Northern California recommended adding a new aspect to the Prepare with Intention element. Very simply, pause before entering the room, (or starting a video or telephone visit) to acknowledge your own explicit and implicit biases that may exist when providing care to this patient. Pause to consider ways to customize your interaction with this particular patient to build trust and show respect.

Conversely, when our patients make biased, discriminatory or racist remarks, as clinicians we must be prepared with a menu of responses that balances our responsibilities to our individual patients to consider the larger societal imperative in which each member of our community learns to cognizant of their own biases.

On June 10, scientists around the world took a day off from their research to reflect on issues around racism and contemplate changes they could make in their lives to dismantle the inequities left by racism. To be most effective in our dialogues with ourselves, our friends and strangers, clinicians must also periodically carve out time to do this hard work. Read books. Collect stories. Develop a repertoire of responses to racist comments.

What actions can PHC take to support this work in the health care arena? We have an internal team focused on many aspects of health equity, including education of PHC staff about implicit bias and review of health disparities data of our members, and planning interventions. One of our core organizational values is valuing diversity as a company and as a leadership team.

We investigate patient complaints involving potential discriminatory behavior, but most do **not** represent overt discrimination (e.g. "I'm not giving you pain medication because you are Black."), but rather those patterns of suboptimal verbal and non-verbal communication driven by implicit bias not subject to civil rights action. Still, such biased communication can be addressed. PHC will look at potential options to do this better in the months ahead.

We welcome your thoughts and suggestions on additional actions we might consider. We are most effective when we work in partnership with you, your organizations and the communities we serve.

Breaking News:

Substance Use Services in the 7 Partnership Counties+

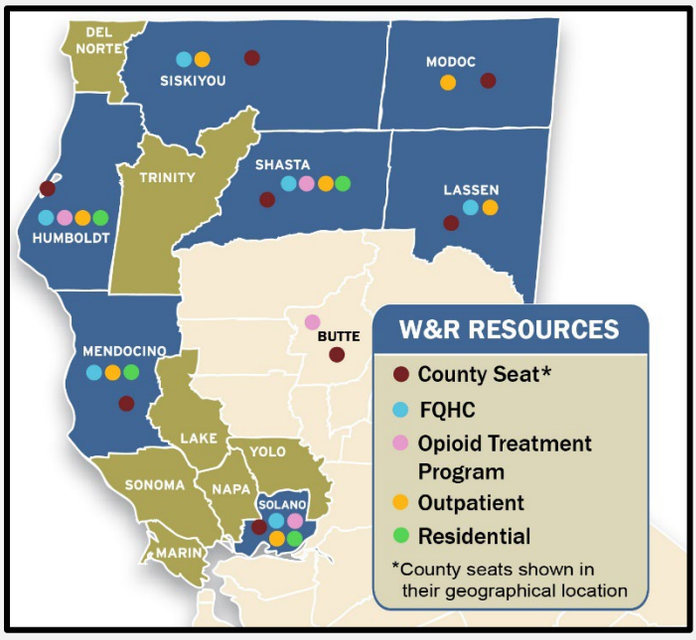
PHC Wellness and Recovery: A Regional Approach

Starting July 1, 2020, PHC will administer the substance use services for seven of its 14 member counties – Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano –This is the PHC Wellness and Recovery (W&R) Program.

PHC and our providers and partners in these seven counties will work together for integrated physical health and substance use services for the Medi-Cal population. Health care services provided by PHC will be more comprehensive and effective as a result.

New Substance Use Disorder Benefits under Medi-Cal

In 2015, a federal waiver allowed California counties to increase access to substance use disorder (SUD) treatment services for adolescents and adults who are eligible for Medi-Cal. The waiver expands Drug Medi-Cal (DMC) reimbursable services beyond outpatient, intensive outpatient, and opioid (narcotic) treatment programs to create a full continuum of care that includes withdrawal management, medication-assisted treatment, short-term residential care, case management, care coordination with physical and mental health, and recovery support services once treatment is completed.



Under this new model, treatment and placement decisions are guided by the American Society of Addiction Medicine (ASAM) criteria. Medical necessity is determined by a licensed physician or other provider. Beneficiaries will access services through phone lines that are available 24 hours a day, seven days a week. Beneficiaries will receive a short ASAM screening, then be connected to the appropriate level of care. Counties/regions opting in to the model need state and federal approval for their programs and fiscal structure.

Benefits of the W&R Program

The W&R Program will bring greater investments in substance use services, drawing from expected savings in other parts of the system, such as reduced emergency room and hospital stays. Other benefits include:

- Participation of small rural counties will allow access to those who would not otherwise be able to take advantage of the expanded benefits.
- More robust rates for providers can support more highly trained staff, expanded use of evidence-based practices, and use of electronic health records.

- New case management and care coordination services can support improved health, mental health, and SUD care and contribute to overall reductions in health care costs.
- Additional levels of care will help beneficiaries suffering from an SUD to receive the right services, at the right time, in the right setting, and for the right duration, and contribute to improved health care outcomes.

Questions about Wellness and Recovery?

Email **wellnessandrecovery@partnershiphp.org**.

Palliative Care E-Consults Now Available

Partnership HealthPlan of California (PHC) and ResolutionCare have partnered to provide palliative care E-consults to PHC's contracted healthcare provider network for PHC primary patients who are 18 years and older. An e-consult is a back and forth PCP to specialist electronic communication about a specific patient, taking place either in lieu of or before a face-to-face visit with the specialist.

Palliative care is patient and family centered care focused on improving the quality of life for your patients. A palliative care consultation may help provide your patients with relief from the symptoms, pain and stress of a serious illness. It is appropriate at any stage of serious illness and can be provided at the same time as disease directed treatment to help your patients live as well as possible while facing serious illness.

Connecting Patients with ResolutionCare Network

For those eligible for the PHC Palliative Care benefit, ResolutionCare's interdisciplinary team works in parallel with the existing medical team and caregivers to provide an extra layer of person-centered support. Our focus of care is symptom management, connecting clients to social services, spiritual support and navigating the health care system when facing a serious illness. An E-consult may assist with such challenges and evaluate patients for eligibility to receive team-based care in their homes.

Benefits to Providers and Patients

- Securely share health information and discuss patient care via a HIPAA compliant email based platform.
- Direct access for Primary Care Providers to ResolutionCare Physicians for consultation and referral of patients that would benefit from palliative Care.
- Faster access for patients to specialty care using telehealth.
- Patient-centered high quality Board Certified Palliative Medicine Physicians.

The Intensive Palliative Care Benefit

Covered conditions include advanced cancer, advanced liver disease, congestive heart failure, chronic obstructive lung disease, progressive degenerative neurologic disease, or other serious pre-terminal conditions that result in frequent hospitalizations. This benefit is designed for PHC members with limitations in function and limited life expectancy who are at a late stage of illness who have received maximal member-directed therapy or therapy is no longer effective.

Palliative care local in-person resources vary by county. For E-consult access or a list of local palliative care providers, please send an email to **econsult@partnershiphp.org**.

California State Budget Uncertainty

The state of California is confronting a massive budget shortfall next year, which will have some major impacts on Partnership HealthPlan. The Governor's May revise called for elimination of 15-20 MediCal Benefits. The legislature restored many of them counting on the Federal Government to come through with a state bail out. The governor may use his line-item veto power to eliminate them again after the budget is signed.

The PHC Board and leadership team is watching the budget process unfold while making contingency plans for likelihood of a major funding shortfall for the next fiscal year.

PCP QIP Changes

PHC has made a number of changes in the PCP QIP in response to the COVID-19 pandemic. You can watch a recording of a May 13 webinar that covers these changes here.

Microdosing Mindfulness

This Blog post on http://phcprimarycare.org reviews the evidence base on mindfulness, with focus on a new technique--microdosing mindfulness—described by the UC Berkeley Greater Good Science Center.

Physicians not trained in Primary Care who want to be PCPs: What does PHC require?

PHC Credentialing policy MR CR 17 "Standards for Primary Care Providers" has been in place for many years and establishes credentialing standards for primary care physicians (PCPs).

Effective June 1, 2020, physicians who do not have defined training or experience as a primary care physician as described in Policy MP CR 17, Section VI.A.4. (either Board Certified in PCP specialty, or 3 year residency in PCP specialty, or 2 years post-graduate training with 1 or more years in PCP specialty) will only be eligible for credentialing as a PCP after they have completed the UC San Diego School of Medicine Physician Retraining and Reentry (PRR) Program, including the practice shadowing component of the program (or a similar program approved by PHC).

Once the program is completed, documentation must be submitted with the credentialing application. The physician must work in a practice with a supervising Medical Director who will monitor the physician's care and provide PHC with a quarterly plan and progress report.

Previously, physicians who did not meet the requirements of Section VI.A.4 were able to submit a letter of recommendation from a supervising physician, with whom they worked for at least a year within a primary care setting, for consideration by the Credentialing Committee. The PHC Credentialing Committee is comprised of primary care and specialist physicians and a nurse practitioner from the PHC Provider network. Physicians approved under the previous policy were often approved subject to certain practice limitations with the results of medical chart review provided to the Committee after six months of practicing primary care. After

several years of approving physicians under this policy, it became clear that physicians not trained in primary care specialties were in need of additional training to ensure quality of care to our members.

You may find a complete copy of Policy MP CR 17 in the Provider Relations Section of the **Partnership HealthPlan of California's Provider Manual** on our website.

In addition, here is the link about the UC San Diego School of Medicine Physician Retraining and Reentry Program **https://prrprogram.com/**.

Immunization Dose Reports Available On-Demand!

The Quality Incentive Program (QIP) Team has announced that Immunization Dose Reports will be available for on-demand access through eReports on Friday, May 8, 2020. These population reports include immunization data for assigned members ages 0-2 and 9-13, along with member contact information, and will be refreshed on a monthly basis. The reports are designed to support member outreach and help engage members sooner, to stay on track with immunizations.

To access Immunization reports, click the "Immunization Dose Reports" link in the eReport user menu.

Accessing and exporting Dose Reports was reviewed in our PCP QIP Measurement Year 2020 Relaunch Webinar on May 13th. You can watch a recording of the webinar here.

New Online Toolkit for Health Care and Treatment Providers of Substance Exposed Mothers and Babies

Formulated by national experts led by the California Maternal Quality Care Collaborative, the toolkit supports neonatal and perinatal providers in addressing the full continuum of care for mothers and babies affected by opioid and other substance use disorders while maintaining the mother/baby dyad whenever possible. This is accomplished through the provision of numerous evidence-based, best practices addressing screening for identification, treatment for the mother and the exposed infant, care transitions, and education options for staff and families. The toolkit considers the intricacies that potential scenarios present: difficulties in screening, stigmatized care, variability of provider and staff knowledge, the challenges of care coordination, and the different settings in which services may be provided. These goals drive a lucidity of purpose to offer safe, effective, patient-centered, hopeful care that is free of stigma and prejudice.

The online toolkit can be accessed here: **https://nastoolkit.org/**

Filling Prescriptions for Blood Pressure Monitors

To help patients monitor their blood pressure (BP) at home, Partnership HealthPlan of California (PHC) covers a variety of blood pressure monitors. In fact, on the **PHC Pharmacy home page**, users can click on the "**Formulary Blood Pressure Kits**" link to see the list of covered items by NDC. The list is updated periodically to reflect BP monitors available on the market. We ask prescribers to write "Blood Pressure Kit" at minimum and include digital, automatic, wrist, upper arm, and cuff size if they want more specificity for the patient. The prescription does not need a Hypertension (HTN) diagnosis and will be covered if the billed amount is less than $100. Write the prescription for a "blood pressure kit," not just a "BP cuff."

PHC Educational Opportunities and Events

Accelerated Learning Education Programs

CME/CE credits available

We acknowledge that the COVID-19 response is changing how health centers and practices approach their daily work and QIP efforts. Wishing to be mindful of the situation, we solicited feedback regarding your ability to participate in the upcoming scheduled webinars. The information received back indicates that most would like the webinars to continue as planned. We want to continue to provide education and resources to help practices on the PCP QIP measures, and will maintain the currently scheduled webinars:

Colorectal Cancer Screening (COL)

Date: Wednesday, June 24, 2020
Time: Noon – 1 p.m.
Sign-Up Now

Cervical and Breast Cancer Screening (CCS & BCS)

Date: Tuesday, August 25, 2020
Time: Noon – 1 p.m.
Sign-Up Now

Recommended Educational Opportunities Outside of PHC

Compassionate Leadership in Times of Crisis

The California Improvement Network sponsored a series of four excellent webinars for leaders which we highly recommend. Taught by Stanford University business professor Leah Weiss, they combine sources of inspiration with tools that health care professionals can use to increase and maintain their won resilience.

CIN Webinars on Compassionate Leadership in Times of Crisis:

- Anchoring in Your Purpose
- Gifting Yourself Self-Compassion
- Extending Compassion
- Applying Mindfulness

Nuka System of Care Conference

CME credits have been requested for Virtual Nuka Week

Southcentral Foundation is no longer hosting the 10th Annual Nuka System Care Conference in-person in Anchorage, Alaska, on June 15-19. They're exploring virtual opportunities to connect and share best practices during that week.

Health care is undergoing a dramatic change from volume-to value-based care, with an emphasis on quality, population health outcomes and whole person care. Southcentral Foundation's Nuka System of Care (Nuka) is an award-winning system in Anchorage, Alaska, that has been providing value-based care for more than 30 years.

SCF's Nuka conference features detailed insights from subject matter experts on topics such as integrated care, data and information management, behavioral health integration, leadership best practices, strategic planning, and more.

Using tools and methodologies unique to Nuka, conference participants walk away inspired by the future of health care and equipped with answers to issues facing their organizations.

Date: July 27-31, 2020
Cost: $299 per person

Sign-Up Now