Medical Directors Newsletter

August 2020

"Medicine is best described not as a science, but as a form of flexible practical reasoning that often uses science."

-- Adam Rodman, MD

Good Medical Decision-Making: Much More than Applying Evidence

How do the best clinicians apply their knowledge?

Last year, this monthly newsletter reviewed the propensity for mental shortcuts, biases and prior experiences that lead to poor medical decision-making, and discussed options for minimizing the degree that these cognitive traps affect our clinical decisions. Think of this as the *cognitive psychology* of medical decision-making.

When mental shortcuts are minimized, and *reasoning* is applied, we might, at first blush, think that the best reasoning limits itself to "Evidence Based Medicine" where high quality, prospective, placebo-controlled, double blind, allocation concealed studies are consistently applied in making medical decisions. In reality, *several sources of knowledge* (sometimes conflicting with each other) are brought to bear. The study of the nature of knowledge is also known as epistemology, a branch of philosophy. Within the medical realm, this is known as *medical epistemology*, a branch of the study of the philosophy of medicine.

In a grand rounds at Beth Israel Hospital in October, 2019, clinical professor Adam Rodman, MD defines a historical framework of medical epistemologies that clinicians use to decide on what treatments to offer patients:

1. **Observation** - This involves obtaining a careful and complete history and physical examination, with review of lab work to categorize the disease or diseases that a patient has, and recalling how similar patients/disease categories that the clinician has directly observed or heard/read about have responded to treatments given. The earliest example of this is the 4,000-year-old Edwin Smith papyrus, in which an ancient Egyptian healer carefully described a series of 48 surgical cases and their treatments.
2. **Theory** - Pre-scientific theories, such as ancient Greek humoral theory of disease dominated medical practice until the mid-nineteenth century, when they were replaced by scientific theoretical frameworks, such as physiology, immunology, biochemistry. These frameworks are then used to interpret observations (such as a rising creatinine in a patient receiving a diuretic), and make judgements based on this understanding.
3. **Experimentation/Clinical Trials** - While there are scattered examples of medical experimentation before 1900, it was not very commonly used. It is primarily a twentieth-century framework, and led to the Evidence-Based Medicine movement, starting in the late 1980s. It includes applying a hierarchy of different types of medical trials and studies, with expert opinion at the bottom of the pyramid and meta-analysis reviews at the top. This pillar of understanding has

crumbled to be replaced with the current standard: grading of available evidence, which takes many other factors into account.

4. **“Population Medicine”/Epidemiology/Biostatistics** - This began in the early 1800s, in Paris and was first called the “Numerical Method.” This involves collecting data on numbers of patients and analyzing this data statistically for insights that can then be used to improve clinical decision making for the individual patient being cared for. The most modern applications of this are decision rules (for example for osteoporosis screening or genetic testing), “big data” analyses, and augmented intelligence medical applications.

Rodman contends that whenever clinicians make treatment decisions on individual patients, we use some or all of these frameworks, even on the same patient, in the same day. The frameworks often might lead to conflicting treatment options which need to be sorted out rationally. Importantly, the third framework is the preferred framework for Evidence-Based-Medicine purists, but real-life excellent clinicians seamlessly integrate EBM with the other 3 frameworks. We need not feel guilty or inferior when we use these other frameworks; they have a vital role in the decision making of all excellent clinicians.

In the end, to the extent medicine uses science, it is in the application of science to deciding on individualized treatment of patients that matters.

The medical ethicist Jose Alberto Mainetti stated it best in his research, *Embodiment, Pathology, and Diagnosis*: "Diagnosis is not knowledge for knowledge's sake. It is knowledge for the sake of action. Medicine exists to cure, to care, to intervene, or in limiting cases to know when not to intervene. Medicine is not a contemplative science."

Knowing the noble history of these four epistemologies can help us balance their use thoughtfully, both in our continuing educational activities to better master them and in applying them to make therapeutic decisions that best serve our patients.

Breaking News

PHC Covers Labcorp’s Home COVID Test

Labcorp is offering a home COVID test that uses the anterior nares collection method.

How it works:

1. Patients must fill out an online questionaire (only available in English, currently) that evaluates eligibility. Individuals with mild symptoms and potential exposure to someone with COVID-19 are eligible. Those with worrisome symptoms are referred to their PCP for evaluation.
2. Patients must enter their PHC ID number for Lab Corps to bill us and a valid email address to receive results. The request is reviewed by a Lab Corp physician for appropriateness who officially orders the test.
3. The patient is then sent a collection kit overnight by FedEx, with a return envelop. The patient collects the sample, puts it into the return envelop and sends it back via FedEx.

4. Results are sent to their email approximatley 2-4 days later (currently). The local public health department is also notified of the results. Patients may forward the results to their Primary Care Provider (PCP) or the PCP may be able to access the results through the physician Labcorp portal (we have heard conflicting info on this last point). While the turnaround time is currently fast, there is a possibility that with increased use of this option that their capacity will be stretched and the turnaround time will increase.

This turnaround time is currently much faster than either OptumServ, Verily or CVS pharmacy, the other options available widely to the public, often through agreements with their local counties. Partnership HealthPlan of California (PHC) will encourage members to contact their PCP if they feel they need or want testing. We wanted to make sure you are aware of this option. If you have a Spanish-speaking patient or a patient without an email, they may need help from your office to navigate this testing option.

Most PCPs are not Billing for ACEs and Developmental Screenings

California is dedicating Proposition 56 Tax revenue to cover a variety of MediCal services and incentives, including incentives screening for Adverse Childhood Events (ACEs) and Develpmental screening of 1-3 year olds. Unlike other incentive programs, all provider types, including Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Tribal Health Centers are entitled to keep the incentives for ACEs ($29 each) and Developmental screening ($59 each), which started on January 1, 2020. For details on how to bill for these screenings to get paid, see this recorded webinar. To note, the ACEs screening now requires providers to complete an on-line training and attest to completion of this training.

Since January, few organizations have been sending in claims for these services. Only **Baechtel Creek Medical Group** in Willits has numbers that suggest a large scale uptake with both screening programs. For ACEs screening, **West Sacramento Pediatrics and Sonoma Plaza Pediatrics** have also submitted over 100 claims; several providers have submitted under 5 claims for this screening. For the Developmental screening, **Mendocino Community Health**, **Marin Community Clinics**, and **NorthBay Healthcare's Center for Primary Care** have submitted large numbers of claims suggesting universal screening. Organizations with 6 to 70 screenings (suggesting that the system is set up but not universally adopted) include:

1. Solano County Family Health Services
2. Sutter Primary Care
3. Communicare Health Centers
4. Open Door Health Centers
5. Shasta Community Health Center
6. Petaluma Health Centers
7. Community Medical Centers

All other primary care organizations have 0 to 3 developmental screening claims since January.

We strongly encourage PCPs caring for children who are not fully taking advantage of these screening dollars to look at their systems and see if they can adapt them to capture this source of revenue.

Oxygen Saturation Monitors, BP Monitors, and Thermometers – No Cost for PHC Members

In response to COVID-19, PHC has obtained a limited supply of blood pressure monitors, oxygen saturation monitors, and thermometers to be given at no cost to PHC members who are patients of FQHCs, RHCs, and Indian Health Services (IHS). PHC would like your help in getting these supplies distributed to our members and your patients who would benefit from this medical equipment.

These supplies will be on a first-come, first-served basis. Interested providers will need to complete the DME Request Form on our website. Complete the form and submit to request@partnershiphp.org or fax to 707-420-7855.

Providers will be expected to connect with the selected PHC members to ensure the member can use the equipment properly.

Prepare for State Prisoner Releases

Due to COVID-19, the California Department of Corrections is planning early release for about 400 prisoners in the next month into the PHC counties. They will be given 30 days of their chronic medication prescriptions and State MediCal for the first month. Most will convert to PHC MediCal the following month and assigned to a PCP the following month, long after their 30-day prescription runs out. These individuals will need to be plugged into a new PCP via virtual visit within the first month of release. If your practice has the capability of accepting new patients, virtually, we ask that you make your providers aware of this situation, and (in general) ensure that new patients are allowed virtual visits during the pandemic.

In addition, the Transitions Clinic at UCSF will be attempting to connect as many of these individuals as they can with a PCP prior to their release. If you have the capacity to accept these individuals as patients, and have a particular case manager that would be the best person for the Transitions Clinic to contact, please email Anna Steiner: anna.steiner@ucsf.edu.

Funding Opportunity for Project ECHO Diabetes

Stanford University's Project Extension for Community Healthcare Outcomes (ECHO) Diabetes, is looking for additional PCPs to join their well-run Project ECHO for Diabetes. The goal is to increase the capacity of PCPs and clinics to empower and safely, and effectively, manage underserved patients with insulin-requiring diabetes who do not receive routine specialty care. Project ECHO is an innovative "Hub-and-spoke" outreach model committed to addressing the needs of the most vulnerable populations by equipping community practitioners with the right knowledge, at the right place, at the right time. Through the use of technology, education and research, Project ECHO demonopolizes specialty knowledge and amplifies the capacity for primary care providers to provide best practice care to their patients. The model was developed out the University of New Mexico in 2003 for

Hepatitis C and has since expanded to over 65 complex conditions in over 200 global sites.

Project ECHO Diabetes is a weekly video-conference based tele-mentoring and tele-education collaborative, Continuing Professional Development (CPD) accredited, case-based learning program. By creating a unique partnership between community healthcare providers and diabetes specialists, the ECHO program and the PCP will enrich and empower each other in practice and work collectively to enhance care for underserved patients with insulin-requiring diabetes. Stanford University will serve as the "Hub" site with a team of multispecialty experts (pediatric and adult endocrinologist, primary care provider, behavior health specialist, nurse/diabetes educator, social worker) to work in partnership with "Spoke" sites (community providers and clinics like yours).

The program is accepting applications for community providers and clinics to join this initiative. Project ECHO Diabetes has cohorts beginning in February 2021 and August 2021. Thanks to the generous support of the Helmsley Charitable Trust, there is no fee to spoke sites who participate.

Apply at this link:
https://stanforduniversity.qualtrics.com/jfe/form/SV_ag9Zd5rMh04rfFj

For more information email Dr. Nicolas Cuttriss at diabetesecho@stanford.edu.

CARES Act Provider Relief Fund

The Provider Relief Funds supports American families, workers, and heroic healthcare providers in the battle against the COVID-19 outbreak. The U.S. Department of Health & Human Services (HHS) is distributing $175 billion to hospitals and healthcare providers on the front lines of the coronavirus response.

Update on August 04, 2020: HHS announced a second extension to the application deadline for the Phase 2 general distribution of Medicaid, Medicaid managed care, Children's Health Insurance Program (CHIP) and dental providers to apply for payments form the Provider Relief Fund. HHS also plans to allow certain Medicare providers who experienced challenges in the Phase 1 Medicare General Distribution application period, a second opportunity to receive funding. **The new deadline for applications is Friday, August 28, 2020 for both groups.**

Additionally, HHS has announced that starting on August 10, 2020, HHS will allow Medicare providers who missed the opportunity, to apply for additional funding from the $20 billion portion of the $50 billion Phase 1 Medicare General Distribution. This reopened application period will last from August 10 to August 28, 2020.

Full Press Release

For more information, please visit the HHS's website.

Reminder: PHC's Wellness and Recovery Program Goes Live!

The Wellness and Recovery Program launched in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties on July 1, 2020.*

Medi-Cal beneficiaries in the seven counties can be screened and connected to a treatment provider by calling Beacon Health Options at (855) 765-9703.

For more information about Wellness and Recovery services, click here.

*Expanded SUD services are available in Napa, Marin, and Yolo counties, and are administered by the counties. A more limited benefit is administered by the remaining four counties – Del Norte, Lake, Sonoma, and Trinity.

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:

Cervical and Breast Cancer Screening (CCS & BCS)

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

Well-Child Visits in the First 15 Months of Life (W15)

Date: Tuesday, September 22, 2020
Time: Noon – 1 p.m.
Sign-Up Now

Childhood Immunization Measures (CIS10, IMA2)

Date: Tuesday, October 06, 2020
Time: Noon – 1 p.m.
Sign-Up Now

Recommended Educational Opportunities Outside of PHC

On-Demand Webinars by ECHO

All available trainings are available on-demand and free of cost:

- Leveraging Telehealth and Remote Monitoring to Support Patients with Diabetes
- Diabetes Patient Needs in the Time of COVID-19
- Continuous Glucose Monitoring (CGM) & Beyond A1c Targets in the Time of COVID-19
- Platforms to Support Remote Diabetes Monitoring in your Practice in the Time of COVID-19
- COVID-19 & Sick Day Management for People with Diabetes
- Identifying High-Risk Diabetes Patients for COVID-19 Triage
- Insulin Dosing & Therapeutic Inertia in the Time of COVID-19
- DPP-4 Inhibitor, GLP-1 Receptor Agonist, & SGLT Inhibitor Therapies
- Tackling Therapeutic Inertia: American Diabetes Association Standard of Care Updates

Sharpening Our Vision for Compassionate Care in the Face of Serious Illness

The Coalition for Compassionate Care of California has moved its excellent annual conference to a virtual format. PHC is sponsoring continuing medical education credit for this event. The content has been concentrated down to two half days of nationally recognized speakers, with an optional virtual poster session in the evening between events. Full details will be posted in the next week or so.

Date: August 24-25, 2020
Time: 8 a.m. – Noon
Sign-Up Now

2020 State of the Art Conference for Substance Use Disorder

CME/MOC credits available

CSAM State of the Art brings together national experts to share frontiers of research, treatments, and policies in the field of Addiction Medicine. This year we do so under the overarching theme of **Frontiers of Access to Care**. Due to the pandemic, our conference will be entirely virtual, and for the first time will span across four weeks. Leading up to the plenaries, half-day workshops will be offered in primary care for individuals with addiction; implementation of treatment in correctional health; motivational interviewing, and addiction psychiatry. The CSAM Addiction Medicine Board Exam Preparation Workshop will be offered August 28th and 29th, and then be posted on the Education Center. Poster presentations will be available on demand.

Dates: August 28 – September 25, 2020
Sign-Up Now