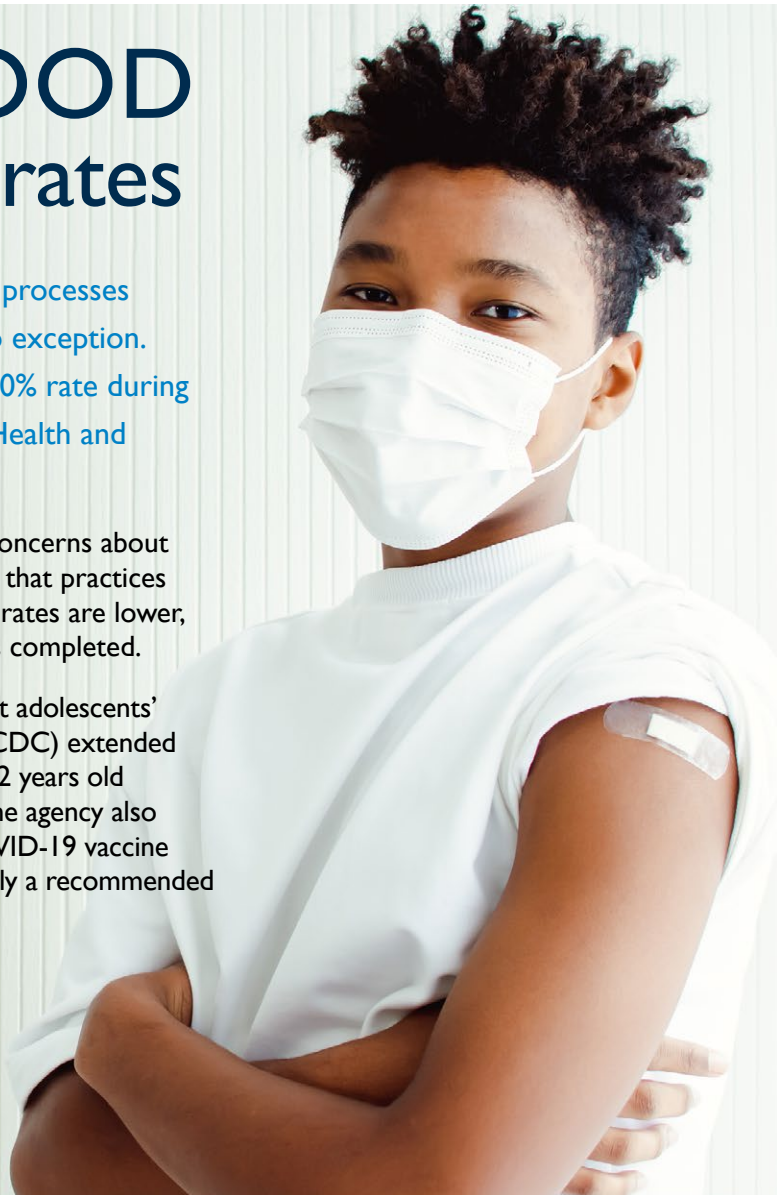
The Pulse of
Summer 2021
The Physician Alliance
10 YEARS
Dedicated to Improving Michigan's Health | 2011–2021

Tips to improve CHILDHOOD vaccination rates



The COVID-19 pandemic affected many preventive health processes in populations across the world. Children and teens are no exception. Michigan's childhood immunization rates slipped below a 70% rate during the pandemic, according to the Michigan Department of Health and Human Services (MDHHS).

Many parents postponed a child's immunizations due to safety concerns about taking their child to a doctor's office during the pandemic. Now that practices have developed safe office procedures and COVID-19 infection rates are lower, parents should be encouraged to get their child's immunizations completed.

The COVID-19 vaccine is another important resource to protect adolescents' health. In May, the Centers for Disease Control and Prevention (CDC) extended COVID-19 vaccine eligibility to include adolescents as young as 12 years old (as of this publication, trials are being conducted on ages 5-11). The agency also updated their clinical guidance to approve administrating the COVID-19 vaccine with other vaccines without a waiting period (there was previously a recommended 14-day waiting period).

This update offers great opportunity for physicians to target adolescents to get up-to-date on vaccines, especially before fall when most K-12 schools are planning on returning to full-time in-person learning.

Childhood vaccination rates *continued on page 3*

In this issue

President's MESSAGE

Dear members,

Good news continues to come from the state's health department and health systems throughout Michigan with the increasing rate of COVID-19 vaccines. The vaccines appear to be lowering severe COVID-19 infections, if not preventing altogether in most. This improvement is attributed to so many partnering in the fight against the pandemic, including all of you.

However, across the nation, and in Michigan, vaccine rates have room for improvement. Providers play an important role in working with patients to get the COVID-19 vaccine. Our 'Coronavirus Resources' webpage continues to be updated with helpful information to encourage patients to get the vaccine. The state is offering many walk-in and pop-up clinics in local communities throughout the summer.

The pandemic brought many health inequities to light for patients. There are many areas for improvement in affordable access to care. We also see opportunities for improvement in processes related to quality reporting, incentives and more. As one of the largest physician organizations in Michigan, with more than 2,300 physician members, The Physician Alliance is positioned to have a strong voice in many areas, including patient care, reimbursement and more. Since our inception in 2011, we have been a leader in pushing beyond boundaries and cultivating new ideas in healthcare, and I promise you that we will keep doing so.

The leadership team and I continue to build relationships with our partners, including Ascension Michigan and Blue Cross Blue Shield of Michigan, to advocate for our physicians. We also are touching base with Michigan State Medical Society, other physician specialty organizations, and patient advocacy groups to ensure the physician voice is heard in state healthcare decision-making.

As we continue to move forward through the COVID-19 pandemic and build the next chapter of a new normal, rest assured that The Physician Alliance team continues to be your partner. The team and I are committed to providing support and resources that help you offer excellent patient care, improve quality scores, and increase revenue for your practice.

In good health,

Michael R. Madden
President & CEO

Childhood vaccination rates *continued from page 1*

Tips for encouraging childhood vaccines

Identify patients who have missed doses. Create an outreach plan to contact these patients to get appointments scheduled.

Be sure to identify the needed vaccines, including the COVID-19 vaccine. Parents look to their child's physician for a source of knowledge and assurance.

Remind parents of the importance of getting adolescents up-to-date on vaccines before returning to full in-person learning in the fall. Vaccines help protect their child from spreadable, yet preventable, diseases.

Assure parents and patients that combining vaccines poses no greater risk for side effects than when vaccines are given individually. According to the CDC, children receive more vaccines to protect against more diseases now compared to 30 years ago. However, the actual number of antigens in vaccines is dramatically less than decades ago because vaccine technology has improved. Today's vaccines are more efficient and also safe to give more than one vaccine at a time.

Share the benefits of combining vaccines into one visit. Some of these include:

- fewer pokes
- fewer office visits
- less money for office visits and copays
- lower risk of children and caregivers being exposed to other germs in office waiting rooms

Helpful adolescent vaccination resources

- Michigan Department of Health and Human Services (MDHHS) created a comprehensive toolkit that offers resources for immunization providers serving adolescents in Michigan. Letters, newsletter articles, flyers, social media graphics, email reminders and more are available at no-cost on the website.
- I Vaccinate is also a helpful website developed by the MDHHS to educate providers, parents/guardians and patients on the safety and importance of vaccinating children.
- Michigan Care Improvement Registry (MICR) offers vaccine schedules, information statements and more.

Helping patients with advance care planning fulfills PCMH capabilities

Encouraging patients to complete an advance care plan helps ensure providers know a patient's preferences during a medical crisis. While it can be difficult for people to think about life-threatening situations, completing advance care planning lets a patient stay in control of healthcare decision-making even if they can't communicate these. Almost 70 percent of Americans don't have an advance care plan, according to the Centers for Disease Control and Prevention.

An advance care directive is sometimes called a living will and part of the advance care plan. It outlines a patient's preferences for healthcare treatment and appoints a decision-maker should the patient not be able to communicate or make decisions. It's important to know that advance care directive guidelines can differ between states.

Being aware of a patient's advance care plan helps a physician understand the patient's wishes and can assist in communicating with family members if the plan needs to be used and the patient is unable to communicate.

Encouraging patients to complete an advance care plan also fulfills two patient-centered medical home capabilities:

- **4.16** ensures a process is in place for conversation with patient about advance care planning, including education and proof of record (of the conversation/education)
- **4.22** indicates that the advance care plan is housed in the electronic medical record and shared with other care team members (specialists, etc.)

Please contact your practice resource team member if you are interested in adding these capabilities.

Free advance care planning tools for patients:

- Ascension created Allay Care, a free tool that guides people through 14 important topics to help uncover what's important when it comes to end of life and after-death care.
- CDC advance care plan guide
- Blue Cross Blue Shield of Michigan advance directive guide
- National Hospice and Palliative Care Organization advance directive guide (Michigan)
- Michigan Health Information Network Shared Services advance directive planning resource

Improving transitional care management

Transitional care management is an important part of managing patients' healthcare needs. Creating effective strategies to follow up with patients post-discharge can help improve care transitions and outcomes. There are many documentation and billing requirements for transitional care management. The following provides a guideline to help with effective transition of care. Download the tip sheet from the Learning Institute on The Physician Alliance's website.

Transitional care management (TCM) services (99495–99496)

99495 – (2.78 RVU) Moderate complexity within 14 days post-discharge

99496 – (3.79 RVU) High complexity within 7 days post-discharge

1111F – Discharge medications reconciled with the current outpatient medication list

Could incorporate these codes as well:

Basic life and/or disability evaluation services: code 99450

Care management services: codes 99439, 99487, 99489, 99490–99491

General behavioral health integration care management: codes 99484, 99492–99494 and HCPCS G2214 (Do not report 99484 in conjunction with 99492, 99493, 99494 in the same calendar month.)

Psychiatric collaborative care management services: codes 99492–99494

Work related or medical disability evaluation services: codes 99455–99456

There are differences in types of medication reconciliation/review

Medication 'review' (which does not involve post-charge) = 1159F and 1160F

1159F – Medication list documented in medical record

1160F – Review of all medications by a prescribing practitioner or clinical pharmacist (such as, Rx, OTCs, herbal therapies, and supplements) documented in the medical record

Medication reconciliation **post-discharge** should be completed and billed with transitional care management codes.

Some insurance payors are reimbursing physician practices for billing the 1111F code. (BCBS is paying $35)

Who can complete the medication reconciliation for transitional care management?

Medication reconciliation requires the medications on discharge be reconciled with the medications the patient was previously taking. The nurse can obtain these medications, but the physician needs to order any changes, additions, or deletions to the medication. Medication reconciliation and management must be furnished no later than the date of the face-to-face/telehealth visit.

Medication reconciliation can help:

- Address medication errors or duplications
- Educate patients on new medications and side effects
- Lower the risk for adverse interactions or readmissions

For the MRP HEDIS measure, documentation from outpatient record must include:

- Date medication reconciliation was performed
- List of current medications
- Notation stating that current medication and discharge medication lists were reviewed
- Signature of prescribing care provider, clinical pharmacist or registered nurse who performed medication reconciliation, or notation of current medications with evidence the patient was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review
- If medications were provided at discharge, please include your patient's next steps such as:
  - Take new medications as prescribed
  - Discontinue all discharge medications
- Notation if no medications were prescribed at discharge

Coding Corner *continued on page 5*

Transitional care management billing requirements

- TCM services can be billed for new and established patients.
- Only one health care professional may report TCM services.
- Bill services (99495 or 99496) once during the total TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services.
- Post-op visits are excluded from TCM services.
- **Providers can bill for new problems (UTI/injury etc.) that develop during the 30-day period with the codes for office visits and virtual visits.**

Care management services include and can be billed in conjunction with (for the same calendar month) per final rule CY 2020 and 2021:

- Advance care planning: codes 99497–99498
- Care plan oversight services: codes 99374–99380
- Cognitive assessment and care plan services: code 99483
- Home health or hospice supervision: codes G0181 and G0182
- End-stage renal disease services: codes 90951–90970
- Chronic care management (CCM) services: codes 99490, 99491, 99487, 99489 (HCPCS G2058 replaced by CPT 99439 CY 2021)
- Prolonged E/M services without direct contact: codes 99358, 99359
- **If the patient is readmitted during the 30-day period, they do not receive the TCM reimbursement.**

Transitional care management documentation requirements

At a minimum, document the following information in the beneficiary's medical record:

- Beneficiary discharge date
- Beneficiary/care giver interactive contact date
- Face-to-face (or now available telehealth) visit date
- Medical complexity decision making (moderate or high)

Transitional care management components

1. The 30-day TCM period begins on the beneficiary's inpatient discharge date and continues for the next 29 days.
2. Contact the beneficiary/caregiver within two business days following a discharge. The contact may be via telephone, email, or a face-to-face visit. **Attempts to communicate should continue after the first two attempts in the required business days until successful.**
3. Conduct a follow-up visit within 7 or 14 days of discharge, depending on the complexity of medical decision-making involved.
4. **Medication reconciliation and management must be furnished no later than the date of the TCM visit (code 1111F).**
5. Obtain and review discharge information.
6. Review the need for and/or follow up on pending test/treatments.
7. Educate the beneficiary, family member, or caregiver.
8. Establish or re-establish with community providers and services.
9. Assist in scheduling follow-up visits with providers and services.

CMO CORNER

By
Karen Swanson
M.D.

Physician implicit bias: "Who, me?"

Healthcare workers, including physicians, generally believe they provide equal care to all patients they encounter. Despite the best intentions of physicians, there is now extensive research suggesting physicians are susceptible to implicit bias which has been shown to contribute to disparities in healthcare.

If you are reluctant to accept this premise, I suggest a web search for "physician implicit bias." The literature supports the presence of implicit bias, also called unconscious bias, in healthcare workers that affects clinical decision-making despite the intention to treat all patients equally.

What does implicit bias mean?

Implicit, or unconscious, bias occurs "outside of the person's awareness and can be in direct contradiction to a person's espoused beliefs and values," according to a Georgetown University project on implicit bias.

Implicit bias does not mean you are a bad person. These biases are activated involuntarily and "differ from conscious biases that individuals may conceal for social and/or political correctness" (Kirwan Institute, OSU).

Implicit bias develops early in life and can have significant influence on interactions and decision-making. Physicians are no exceptions. Implicit bias frequently conflicts with a person's beliefs about minority statuses, including race, gender, weight, age, ethnicity, socioeconomic status, disability and height. Addressing implicit bias ranks third among top priorities at the National Institutes of Health because of the effects on health care disparities.

Why are organizations suddenly requiring training on implicit bias?

The short answer to this sudden focus on implicit bias is COVID-19. The disparities in healthcare access, treatment and outcomes during the pandemic awakened many in communities, government agencies, businesses, and public health. Despite best intentions, some healthcare disparities linked to implicit bias likely led to increased morbidity and mortality in minority populations during the pandemic.

How does a clinician determine their degree of implicit bias?

Variations of an implicit association test (IAT) have been used in multiple healthcare disparity studies to measure physician implicit bias. Harvard's Project Implicit website offers various online IAT tests (focused on skin color, gender, etc.) at no cost. The test is a computerized timed dual categorization task that measures unconscious preferences by bypassing conscious processing. I took several versions of this test and was definitely surprised at the results.

Many studies have confirmed implicit preference for whites among physicians is common. A landmark study by Sabin et al. 2009 demonstrated that the presence of pro-white bias was significant among physicians of all races except African American. Women and pediatricians were found to have less pro-white bias than men and other specialties.

Examples of care inequities include:

- *Implicit Bias Among Physicians and Its Prediction of Thrombolysis Decisions for Black and White Patients* by Green et al. 2007 demonstrated physician implicit biases contribute to racial/ethnic disparities in the use of thrombolysis for myocardial infarction.
- Studies have shown African Americans are less likely to receive evidenced-based care for stroke, MI and heart failure.
- African American and Hispanic patients are significantly less likely than whites to receive pain medicine for acute injuries, including fractures.
- Women are three times less likely to be referred for a total knee replacement than men.

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REMINDER

Unconscious bias training required for specialty incentive eligibility

Unconscious, or implicit, bias occurs when people act on ingrained stereotypes and attitudes without meaning to do so. This unconscious bias occurs in many aspects of society, sometimes with heavy consequences. This is especially true in the health care setting.

Racial and ethnic health disparities exist in the leading causes of morbidity and mortality in Michigan and nationally, according to National Healthcare Disparities report.

Reducing healthcare inequities

Unconscious bias in medicine training seeks to reduce barriers and disparities in access to and delivery of health care services. It also teaches how to recognize and understand the impact that perception, judgement and actions may have in inequitable decision-making, communication, and access to and delivery of health care services (MI LARA).

Earlier this year, Blue Cross Blue Shield of Michigan (BCBSM) implemented an unconscious bias training requirement for all primary care physicians participating in their Physician Group Incentive Program (PGIP). The Physician Alliance (TPA) primary care physicians needed to complete the training by June 30, 2021 to be eligible for nomination to BCBSM's patient-centered medical home designation.

TPA selected Stanford University School of Medicine's Unconscious Bias in Medicine program to fulfill the BCBSM training requirement. The program uses existing research, case studies with examples of unconscious bias, self-assessment opportunities, and more to help "learners understand how to bring the content into their own unique environments."

As part of TPA's PGIP incentive eligibility, **ONE physician per specialty practice** participating in the PGIP through The Physician Alliance **must complete the Stanford University Unconscious Bias in Medicine training by Oct. 1, 2021.**

State moves to remove barriers to care

In June, Governor Gretchen Whitmer signed legislation requiring health care professionals in Michigan to complete an implicit (unconscious) bias training to obtain or renew their state licenses, effective June 1, 2022. Under the rules, new applicants for licenses or registration will have to complete at least two hours of implicit bias training, and those renewing licenses will complete at least one hour of training each year, according to Michigan's Department of Licensing and Regulatory Affairs. The department is still developing the final rules.

Attention specialty practices!

ONE physician per specialty practice must complete the Stanford University Unconscious Bias training by Oct. 1, 2021 in order for all practice physicians to be eligible for the The Physician Alliance PGIP incentive.

A certificate of completion must be emailed to thephysicianalliance@thephysicianalliance.org to receive credit for completing the incentive eligibility requirement.

Member discount program offers special pricing and solutions

The Physician Alliance's **Affiliate Partners Program** offers special savings on needed products and services to member practices. Highlights of current partner products and services are listed below. Additional information on each Affiliate Partner can be found on The Physician Alliance website or directly contact the companies.

Don't miss exclusive summer specials!

(denoted by the orange bars)

Cyber Liability Insurance
Huntington Insurance

Contact: Rick Loss
rick.loss@huntington.com
(419) 720-7911

Legal Services
Rickard & Associates, P.C.

Required, annual HIPAA or compliance training for only $499 (average savings of 50%)!

**Training includes a one-hour meeting prior to a one-hour training. Additional time, services, or trainings will be billed at an hourly rate. The meeting and training may be in-person or via Zoom/telephone. This promotion expires 9/30/21 and must be used by a current TPA member.*

Contact: Lori-Ann Rickard
info@larlegal.com, (586) 498-0600

Medical Answering Service
Ambs Call Center

Contact: Aaron Boatin or Ryan Ambs
sales@ambscallcenter.com
(586) 693-3800

Medical Debt Collection
Transworld Systems, Inc.

Contact: Michael Glass
michaelglasstsi.com, (248) 914-0346

Medical Malpractice Insurance
Coverys

Contact: Tina Jensen
tjensen@coverys.com, (517) 886-8345

Mortgage & Banking Services
Huntington Bank

An enhanced lending program for physicians only that allows ZERO down up to $1 million with NO PMI.

Mortgage contact:
Sandra Frith
sandi.frith@huntington.com
(586) 749-8355

Banking services contact:
Ashley Boday
Ashley.boday@huntington.com
(248) 554-6618

Office Supplies & Solutions
Office Depot

Contact: Alexis Sultenfuss
Alexis.Sultenfuss@OfficeDepot.com
(855) 337-6811 x12734

Payroll/HR Services
DynamicHR

New clients receive TWO months of FREE administrative fees with payroll services.

Contact: Andrew Tafel
atafel@dynamichr.com
(248)-648-7886

Practice Marketing Services
4MJ Social

FREE reputation management services through Labor Day.

Contact: Bobby Dimovski
bdimovski@4mjsocial.com
(248) 788-6250

Telephone Solutions and Services
Edge Solutions

Sign up with hosted voice services and receive two great offers:

- FREE installation
- Receive professionally recorded auto attendants that include day, night and a special greeting for only $29.95 (normally $89.95)

Contact: Walt Rush
walt@edgesolutionsllc.net
(888) 918-3343

Vaccine Purchasing Program
Atlantic Health Partners

Contact: Rand Deuchler
rdeuchler@atlantichealthpartners.com
(800) 741-2044

Wealth Management Services
Morgan Stanley

Contact: Joe A. Ghanem
joe.ghanem@morganstanley.com
(313) 642-5909

Physician implicit bias: "Who, me?"

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- Women with similar histories and exam are much less likely to be diagnosed with COPD than men.
- Elderly patients are less likely to be treated for suicidal ideation even though geriatric patients are at high risk for suicide.
- A significant number of physicians specializing in obesity were found to have unconscious biases related to obesity.

If physicians are willing to acknowledge they are susceptible to implicit bias, like everyone else, there is the potential to manage these biases. You can't eliminate implicit bias. It is, in some respect, your DNA. However, you can receive training to manage your biases, which is necessary to reduce healthcare disparities. Below are some recommended action items:

- Take the Harvard IAT online test. In a Mayo clinic study, 67% of physicians who took the test thought it might be helpful in reducing bias.
- Complete targeted education to mitigate the effect of implicit bias on clinical decision making. Start by taking the Stanford Unconscious Bias training webinar.
- Use evidence-based medicine in clinical situations.
- Tell co-workers you are aware of your biases and ask them to call you out on your interactions with patients.
- Individuating (focusing on specific medical data about a patient vs socioeconomic/ethnic information) has resulted in more evidence-based decision making in several studies.

I was initially suspect about the effect of implicit bias on healthcare outcomes. After reading multiple studies, it is obvious implicit bias is present in physicians and correlates with unequal treatment of patients. I encourage you to read more on this topic. We need to expose any biases, in ourselves and others, to effect positive change.

The Physician Alliance
Dedicated to Improving Michigan's Health

Help us keep connected with you!

(586) 498-3555 | thephysicianalliance.org

To ensure TPA news and announcements reach you, please make certain any changes in contact information (name, email, address, phone) are shared with us: thephysicianalliance@thephysicianalliance.org