SAN FRANCISCO MEDICINE

JOURNAL OF THE SAN FRANCISCO MEDICAL SOCIETY

Cultural Competency

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Asian Health Services

The Changing Face of Geriatric Care in the AAPI Community

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- *Clinical Practice: Choosing Wisely*
- *SFDPH Influenza Update*

Covered California

Your Practice, Your Patients, and You

VOL. 87 NO. 1 January/February 2014

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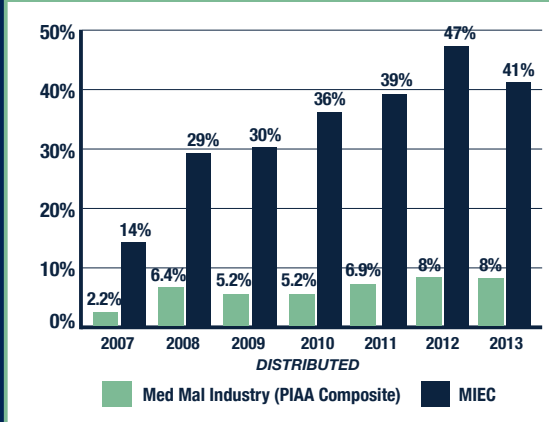

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Cultural Competency

FEATURE ARTICLES

OF INTEREST

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MONTHLY COLUMNS

Editor's Note: The SFMS would like to thank a contributor to our PAC who donated after the last issue of the journal with a suppoerter list was published. Thank you Joel W. Renbaum, MD, for your support.

Welcome New Members

The SFMS would like to welcome the following members:

Payal Nilesh Bhandari, MD | *Family Medicine*
Christopher Chee, MD | *Child and Adolescent Psychiatry*
Marisa Anne Gardner, MD | *Child Neurology*
Sonia Lee, MD | *Radiology*
James Michael Lindsey, MD | *Pathology*
Monica Elizabeth Mazda, MD | *Neurology*
Lorenzo Nardo, MD | *Radiology*
Wei Rao, MD | *Internal Medicine*
Christina Eve Schroeder, MD | *Obstetrics and Gynecology*
Jeffrey Lorren Seal, MD | *Psychiatry*
Aaron Spicer, MD | *Pediatrics*
Joan Margaret Striebel, MD | *Addiction Psychiatry*
Linda J Tang, MD | *Radiology*
Jonathan Efram Volk, MD | *Internal Medicine*
Alan Lingqi Zhang, MD | *Orthopaedic Surgery*
Xiaosong Zhang, MD | *Hematology Oncology*
Etay Ziv, MD | *Radiology*
Sundeep Grandhe, MD | *UCSF student*

MEMBERSHIP MATTERS

Activities and Actions of Interest to SFMS Members

Covered California Provider Resources

SFMS/CMA have developed several resources to help educate physicians on the exchange and ensure that they are aware of important issues related to exchange plan contracting.

More than seventy physicians and office managers participated in the SFMS seminar about the risks and benefits of Covered California products in early January. Brett Johnson, JD, MPH, CMA's associate director for Medical and Regulatory Policy, addressed issues regarding reimbursement rates offered through the Covered California products and provided tips on payor contracts. SFMS would like to thank St. Mary's Medical Center for providing the meeting space and lunch for this event. Additionally, SFMS/CMA members and their office staff have access to complimentary on-demand webinars about Covered California at http://bit.ly/1kZ23Mm.

SFMS can provide you with educational materials in English, Spanish, and Chinese to distribute to patients who ask for information about Covered California. If you are interested in receiving resources for your office, please contact Ariel Young at ayoung@sfms.org or (415) 561-0850 x200.

Obama Signs Medicare SGR Reform Act of 2013, Stops Physician Pay Cut for 3 Months

The Pathway for Medicare SGR Reform Act of 2013 was signed into law, preventing a scheduled 24 percent Medicare physician payment cut from taking effect on January 1, 2014.

The new law stops the cuts called for under the sustainable growth rate (SGR) for three months and instead provides a 0.5 percent update through March 31, 2014. The three months gives Congress time to finalize the Medicare payment reform legislation.

The Centers for Medicare and Medicaid Services is currently revising the 2014 Medicare Physician Fee Schedule to reflect the new law's requirements as well as technical corrections identified since publication of the final rule in November. The new law also extends the exceptions process for outpatient therapy caps through March 31, 2014.

Noridian to Send out Medicare Revalidation Requests

As called for under the Affordable Care Act (ACA), Medicare Administrative Contractors (MACs) have been requiring physicians to revalidate their Medicare enrollments. Between now and March 23, 2015, MACs will continue reaching out to physicians, notifying them of the need to revalidate. Noridian, MAC for California, sent out a round of revalidations requests in December.

The revalidation requirement is necessitated by new screening criteria called for under the ACA. Newly enrolling and revalidating providers will be placed in one of three screening categories representing the level of risk to the Medicare program. The level of risk will determine the degree of screening to be performed when processing the enrollment application.

Physicians who receive a request for revalidation must respond to that request within 60 days or face the possibility of being deactivated. **Do not do anything until you get a letter** instructing you to revalidate. Physicians who are making changes (moving, closing practice, etc.) should continue to submit their changes as usual.

For providers in PECOS: The revalidation letter will be sent to the special payments and correspondence addresses simultaneously. If these are the same, it will also be mailed to the primary practice address.

For providers NOT in PECOS: Revalidation letters were sent earlier this year to the special payments or primary practice address. If you are not in PECOS and have not already received a letter, contact Noridian for guidance.

To find out whether you have been mailed a revalidation notice, go to CMS's revalidation page at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidations.html. If you are listed and have not received the request, contact Noridian at (855) 609-9960.

New MICRA Brochure Available for Patients

The CMA-led coalition working to protect California's landmark Medical Injury Compensation Reform Act (MICRA) has published a patient education brochure to help inform California voters about the ballot initiative being pushed by trial attorneys. The ballot measure would impact access to care for patients, causing community health centers and physician offices across the state to close.

MICRA opponents have already begun collecting signatures in an attempt to place language on the November 2014 ballot. California trial lawyers are attempting to lift MICRA's cap on speculative, noneconomic damages, presenting ballot language that seeks to more than quadruple the maximum award for noneconomic damages to roughly $1.1 million. A change like that would mean increased health care costs for everyone, and decreased access to care that many patients count on.

The well-funded opponents, led by the trial lawyers, have already poured more than a million dollars into the campaign to undo MICRA. The threat against MICRA is more serious now than it has ever been, which is why together, with nearly 1,000 organizations dedicated to protecting MICRA, we must fight back.

There is no doubt that physicians understand how catastrophic a measure like this would be for access to affordable health care. To win this fight, voters, our patients—those we interact with every day in our practices—must understand the fact that protecting MICRA goes hand in hand with protecting access to quality health care in California. The pamphlet "Patients, Pro-

viders, and Healthcare Insurers to Protect Access and Contain Health Costs" is about educating patients on the real impacts the proposed ballot measure would have, if passed. If you think this information would be of benefit to your patients, contact Yna Shimabukuro at yshimabukuro@cmanet.org or call (916) 551-2567 to receive fifty copies for your office.

SAVE THE DATE: Former Secretary of State Hillary Rodham Clinton will headline the 2014 Leadership Academy

Hillary Rodham Clinton, former Secretary of State and former U.S. Senator from New York, has been confirmed as the keynote speaker for the 17th annual Western Health Care Leadership Academy. This year's Academy (formerly the California Health Care Leadership Academy) is scheduled for April 11–13, 2014, at the San Diego Convention Center.

Top thinkers and doers will share strategies and resources for accelerating the shift to a more integrated, high-performing, and sustainable health care system. The conference will examine the most significant challenges facing health care today and present proven models and innovative approaches to transform your organization's care delivery and business practices. Topics will include leadership development, ACA implementation, practice management, and the ICD-10 transition.

Visit www.westernleadershipacademy.com for more details.

Governor Brown's Initial 2014–2015 Budget Proposal

Governor Brown released the third state budget of his current term, outlining 2014–2015 General Fund spending of $106 billion, a 7 percent increase over the $98 billion in General Fund spent in 2013–2014.

The 2014–2015 budget includes increased spending for federal health care reform, mental health, and substance use disorder services. The two issues of concern to physicians include:

• **AB 97 (2011–2012 budget) 10 percent provider rate reduction.** As a result of SFMS/CMA's steadfast campaign advocating for the elimination of the Medi-Cal cuts, the Governor's budget stops the retroactive collection of the 10 percent cut that was a result of provider reductions made in AB 97, a trailer bill associated with the 2011–2012 state budget. The Governor's budget still reflects prospective cuts to already abysmal Medi-Cal rates, which are scheduled to take place this month. CMA continues to fight to eliminate prospective reductions and advocate for more reasonable Medi-Cal rates.

• **Coordinated Care Initiative (CCI)/"Duals pilots."** The budget proposal notes changes in the Coordinated Care Initiative (CCI) that have occurred since the enactment of the 2013 budget act. Beginning in April 2014, dual eligibles will be enrolled in all participating counties except Los Angeles, Alameda, and Santa Clara counties. In Orange, Riverside, San Bernardino, San Diego, and San Mateo, counties' passive enrollment will begin on April 1, 2014.

Enrollment will be phased in over twelve months in all participating counties, with the exception of San Mateo County, which will happen all at once during the first month. The remaining three counties (Los Angeles, Alameda, and Santa Clara) will not begin before July 1, 2014.

Complimentary Webinars for SFMS Members

CMA offers a number of excellent webinars that are free to SFMS members. Members can register at www.cmanet.org/events.

February 19: Transitioning Your Practice: Retiring, Selling, or Buying a Practice • 12:15 p.m. to 1:15 p.m.

February 26: Fraud and Abuse: Dangers and Defenses • 12:15 p.m. to 1:15 p.m.

March 5: HIPAA Security Risk Analysis: How to Make Sense of This Requirement • 12:15 p.m. to 1:45 p.m.

January/February 2014

Volume 87, Number 1

Editor Gordon Fung, MD, PhD
Managing Editor Amanda Denz, MA
Copy Editor Mary VanClay

On January 1, 2014, Covered California began providing health coverage to more 400,000 patients statewide. With that figure expected to grow by the end of the 2014 open enrollment period, it is critical that physicians and their staff know what to expect.

Here are five tips to survive the first month of Covered California.

1. Check your participation status with the various exchange plans through the Covered California provider directory.

The search function on the Covered California website allows patients to determine whether a particular physician is contracted with any of the participating health plans. Though aimed at patients, physicians can also use the search to determine which plans list them on their exchange provider directories and will also be important as physicians refer patients to other specialists. To access the provider directory:

- Visit www.CoveredCA.com and click yellow "Apply Now" button.
- Select the "Preview Plans" tab at the top of the next screen.
- The user will then be directed to provide some general demographic information and click "See My Results" at the bottom right.
- Click "Preview Plans" again on the next page, then select the "Find your doctor or hospital/clinic or medical group" bar in the middle of the screen.
- Click "Find Your Doctor."
- Enter the physician's name and location of practice (e.g., city or zip code) and click "Search." If the desired physician is contracted with a participating Covered California health plan, his or her name should appear in the subsequent provider list.
- Click on the desired physician's name. Review the information listed in the "Specialty Designation" and "Languages" fields then click the "Add to My Providers List" option.
- Click "Choose a Plan." The plans in which the chosen physician participates will show a gray check box in the "My Doctors" row within the summary at the lower half of the page. A gray minus-sign box indicates the physician does not participate in the plan.

Step-by-step instructions with screenshots are available on www.sfms.org to help physicians navigate through the physician directory.

SFMS/CMA conducted a number of test searches and noted inaccuracies or missing information with some of the information on the Covered California website. For this reason, we recommend practices check the individual plan websites to confirm that their participation status matches that of Covered California. It's important that the front office staff have a clear understanding of which plans the practice participates with so they can clearly communicate this information to patients before scheduling.

2. Physicians with questions or concerns about their participation status are encouraged to contact the plan directly.

- If you show as participating and aren't sure how/why, ask the plan to provide a copy of the notice they sent to you, including the terms (e.g., reimbursement rates, termination/opt-out provision, etc.).
- If you are listed as nonparticipating and are interested in joining the network, inquire with the plan about how to join the exchange networks.

SFMS has compiled a list, below, of the exchange plans (minus Kaiser) and phone numbers for practices to call with questions about their participation status with each exchange plan.

Anthem Blue Cross: (855) 238-0095 or networkrelations@Wellpoint.com

Blue Shield of California: (800) 258-3091

Health Net of California: (800) 641-7761 or provider_services@healthnet.com

Chinese Community Health Plan: (415) 216-0088 x2806 (CCHP has tasked the Chinese Community Healthcare Association to handle this issue)

The practice should also submit a brief description of any error to Covered California at ProviderDirectoryInp@covered.ca.gov.

3. What will Covered California ID cards look like?

All Covered California ID cards will display the Covered California logo in addition to the plan name.

4. What if an exchange patient presents without an ID card?

Coverage for patients who enrolled in an exchange plan by December 23, 2013, became effective January 1, 2014. Covered California extended until January 15, 2014, the deadline for patients to submit their first month's premium. Once payment is received, plans have ten business days to issue patient ID cards. This means patients may present to your office without an ID card. Until the practice can verify eligibility and benefits, physicians can require patients to pay at the time of service. Once the patient provides the practice with the information on his or her ID card, the practice can verify eligibility for the date of service, submit a claim to the plan, and issue a refund to the patient, if appropriate.

Patients who did not pay their first month's premium by January 15 are responsible for payment of any services incurred dating back to January 1.

5. Still have questions?

SFMS has developed several resources to help educate members on the exchange and issues related to exchange plan contracting. Visit http://bit.ly/1kZ23Mm for a list of resources.SFMS members and their staff also have free access to CMA's reimbursement helpline at (888) 401-5911 or economicservices@cmanet.org.

Understanding the Grace Period for Subsidized Exchange Enrollees

Federal law allows Covered California enrollees who receive financial subsidies to keep their health insurance for three months, even if they have stopped paying their premiums. This is known as the "grace period."

The first month of this grace period will be treated normally, and plans must pay for services rendered. In months two and three, however, the health plan may suspend payment for any services provided to these enrollees—and deny the claims if the enrollee's coverage is terminated for non-payment of premiums at the end of the third month.

In California, health plans will be required to suspend a subsidized enrollee's coverage if the enrollee has not paid his or her premiums for more than a month. The health plans also will generally be required to notify the enrollee's physician that the enrollee has entered month two of the grace period.

Covered California's 3-Month Grace Period for Non-payment of Premiums		
1st Month of Delinquency	**2nd and 3rd Months of Delinquency**	**Terminated After 3 Months of Delinquency**
• Normal payment of claims • Plan effectively treats this month as paid even if enrollee is eventually terminated for non-payment • No provider notification of the patient's delinquency	• Eligibility verification should indicate inactive coverage • The plan has the option to suspend payment for claims on services performed until the enrollee pays the outstanding balance, and any providers submitting claims for these patients will not be paid until patient is current. • Certain providers are notified of patient's grace period status within 15 days of month two. • If enrollee pays off the balance, providers' claims are paid at that time and enrollee's coverage is reinstated. Certain providers receive a notice of the enrollee's reinstatement.	• Plan has the option to deny all claims for services performed in the 2nd & 3rd months of delinquency. • Providers may seek payment for denied claims from the patient. • Patient may then enroll in a different Exchange plan at next open enrollment despite the delinquency.

Frequently Asked Questions (FAQ)

How will I know who gets the 3-month grace period?

Insurance ID cards for exchange enrollees will have the Covered California logo on them, but they will not indicate whether the enrollee is subsidized. Current enrollment trends, however, predict that 85 percent of those with exchange coverage will be subsidized and receive the three-month grace period.

How will I know whether an exchange patient is in months two or three of the grace period?

Practices should verify an exchange patient's eligibility as near the time of service as possible. If the patient is in months two or three of the grace period, the health plan should indicate that coverage is inactive. Furthermore, within 15 days of entering month two of the grace period, the plan is required to notify the primary care provider (PCP) of record and any physicians who have submitted claims on the patient within the previous two months.

What are my options if a patient presents with inactive coverage on account of the grace period?

Practices should have policies in place prior to March 2014, the earliest date that patients may begin entering month two of the grace period. Practices may, for example, require a patient to sign an agreement that they will be responsible for all unpaid charges and may request a payment up front. A practice, however, must consider its own circumstances and, for instance, to what extent applying its current policies on treating uninsured or self-pay patients may be suitable.

HEALTH CARE REFORM

Andrew Calman, MD, and Steve Heilig, MPH

The ACA, Your Practice, and You

The initial rollout was a disaster. Of the people who were supposed to benefit from health care expansion, few said they understood the new law. Its approval rating was a dismal 28 percent, and opposition was fierce.

The year was 1966, and under the guidance of Bay Area native Philip R. Lee, MD (assistant secretary of health, later chancellor of UCSF, and longtime SFMS member), the new program called "Medicare" overcame its initial stumbles to become successful and overwhelmingly popular.

Fast-forward to 2014, when another Lee—Peter Lee, Phil's nephew and formerly chair of the Pacific Business Group on Health—is overseeing the rollout of Covered California, California's health exchange under the Affordable Care Act—aka "Obamacare." Unlike the federal website (healthcare.gov) used by some thirty-four states, Covered California's website (coveredca.com) has been feature-rich and relatively glitch-free, leading to robust early enrollment numbers (although the "provider directory" has been more problematic but is being fixed).

The first San Francisco enrollees have already received their Covered California insurance cards.

Some Covered California enrollees have started seeing physicians, although uninsured Californians have until March 31 to sign up for coverage and avoid a tax penalty. Instead of focusing on the politics, let's look at the practical issues of what these patients—and their doctors—can expect from this new program.

Although there is a small-business option in the early stages of implementation, Covered California primarily impacts the individual health insurance market. Preexisting conditions are no longer a barrier to coverage. All individuals (except undocumented immigrants) who are not covered by an employer-sponsored or government insurance program are eligible to enroll. All programs must offer a defined, comprehensive benefits package; guaranteed issue; community rating (adjusted only for age and smoking history); preventive care without co-payments or deductibles; and an annual out-of-pocket cap between $2,250 and $6,350. Patients who were previously enrolled in plans that do not meet these requirements, and who desire a plan with less coverage than the standard plan, have been offered reissue for one year or may enroll in a Covered California plan.

Depending on family income, individuals and their families will be eligible for Medi-Cal, subsidized private insurance, or unsubsidized private insurance. Families earning below 133 percent of the Federal Poverty Level (FPL, about $15,000 for an individual or $31,000 for a family of four) will qualify for Medi-Cal. For the first time, this includes Medi-Cal eligibility for adults without dependents, and it also includes expanded mental health and dental care. This expansion is expected to increase the Medi-Cal enrollees by about 20 percent. Most new enrollees will be nondisabled adults between the ages of eighteen to sixty-four and will receive care through the San Francisco Health Plan, which administers Medi-Cal HMO's through the Community Health Network (SFGH and its satellite clinics), Kaiser, Brown & Toland, Hill Physicians, and Chinese Community Health Plan. Eligibility and claims should be no different from those for current managed Medi-Cal enrollees. Physicians contracted with these plans should expect to see a substantial increase in Medi-Cal patient load.

The Affordable Care Act specifies a provider subsidy for primary care (but not specialty care) for 2014 and 2015. Unfortunately, implementation of these rates in California has not been finalized. Meanwhile, providers are struggling with Medicaid rates that are among the lowest in the nation. Although SFGH and its affiliated community clinics have received funding to expand primary care and other services, it remains an open question whether enough providers will be available any time soon to care for this increased Medi-Cal population.

Individuals and families earning between 133 percent and 400 percent of FPL (up to about $46,000 for an individual or $94,000 for a family of four) will qualify for subsidized private insurance through Covered California. This encompasses a large number of working-class and middle-class families, from baristas to independent professionals to seasonal construction workers. Individuals and families earning over 400 percent of FPL can still purchase insurance through Covered California, but without the sliding-scale federal subsidies. In San Francisco, Covered California has contracted with five health plans for 2014 and 2015: Kaiser HMO, Anthem Blue Cross EPO, Blue Shield PPO, Healthnet PPO, and Chinese Community Health Care Association (CCHCA) HMO. Other insurers, such as Aetna, Cigna, and United Healthcare, are not currently participating in Covered California. The Healthy San Francisco program will continue to exist, primarily for undocumented immigrants, but most current Healthy San Francisco enrollees will receive coverage through the Medi-Cal expansion or subsidized Covered California private plans instead.

Prior to the ACA, those venturing into the individual insurance market too often encountered high premiums and very limited coverage, if they were fortunate enough to obtain in-

surance at all. Premiums through Covered California should be within reach for most consumers. Individuals and families can choose from Platinum, Gold, Silver, Bronze, and Catastrophic plans; those with lower income can also choose Subsidized Silver, which has lower deductibles and co-payments. An example of unsubsidized coverage for a hypothetical forty-year-old self-employed physician shows that a Bronze plan can be purchased for as little as $221 per month, regardless of health or income. And, like all Covered California plans, the possibility of medical bankruptcy is virtually eliminated. Even if this physician were to require bone marrow transplantation or coronary bypass, the annual out-of-pocket maximum would still be $6,350, the premiums could not be raised, and the policy could not be canceled due to illness.

It is estimated that 28,000 San Franciscans will qualify for subsidies to purchase private insurance through Covered California. If our hypothetical forty-year-old was a fast-food worker earning $17,000 per year (150 percent of FPL), she would pay a Subsidized Silver plan monthly premium of between $0 and $76, depending which insurance plan she selected, and would benefit from subsidized co-payments and deductibles and an annual out-of-pocket maximum of $2,250. If she were a receptionist making $29,000 per year (250 percent of FPL), she would pay between $126 and $212 per month. Two fifty-one-year old adults with two children and a combined income of $60,000 could cover the entire family with a monthly premium of only $2 (two dollars) for a Bronze plan or $267 for a Silver plan. You may want to go to coveredca.com and use the "Shop and Compare" tool to explore these and other examples for yourself.

From the physician's perspective, these patients will not be very different from existing HMO and PPO patients covered by these same private plans. Offices will need to check eligibility and obtain referrals and authorizations, just as with current patients. Some of these patients have never had insurance before and may need to be educated about co-payments and deductibles. Some plans may use their existing provider networks, while others may have "narrow networks" that exclude some providers. Payment rates may or may not be the same as with current patients under existing plans. It is essential that physicians inquire directly with their contracted health plans to determine their network status and payment rates. California's Knox-Keene regulations should ensure that physicians are paid by health plans for eligible patients; CMA is working hard to make sure that even if patients do not pay their insurance premiums on time, their doctors will still be reimbursed for services.

The ACA has its most profound impact upon those who currently do not have insurance. However, the ACA has also allowed more than 3 million young adults to be covered by their parents' health insurance, is closing the "doughnut hole" for Medicare prescription drug coverage, and has provided rebate checks for 8.5 million Americans whose insurance companies spent less than 80 percent of revenue on health care. There are also subsidies for small businesses (including medical practices) that offer health insurance for their employees. For more details on the ACA, including how the ACA is funded and potential long-term issues, see Dr. Calman's previous article in *San Francisco Medicine,* October 2012 (available at sfms.org).

For all the clamor about the world-changing or world-ending impact of Obamacare, we expect that after a few months of growing pains, Covered California will become just another part of the health insurance landscape that most of us encounter every day, joining employer-sponsored HMOs, PPOs, Medicare, Medi-Cal, and the occasional self-pay patients we see in our practices. Efficient practices will see a positive impact on their finances. Covered California patients will have insurance cards, co-pays, authorizations, and referrals just like everybody else. Many will have health problems that have long been neglected, which we can use our skills and knowledge to alleviate. The battles over contraceptive coverage and other issues will be resolved in the courts of last resort. The "cost curve" will be monitored and debated, with great difficulty firmly linking these reforms to cost changes (as is already the case—health care cost increases are down recently, but nobody is really quite sure why yet).

The heavy opposition to the ACA is really nothing new—Presidents Roosevelt, Johnson, Nixon, Clinton, and G.W. Bush all faced severe attacks when they rolled out new programs, from Social Security to Medicare and Medicaid and senior prescription drug benefits.

All such programs had difficult births and have needed continual refinement, but few have argued for their complete repeal. We do know it is a good thing for as many Americans as possible to have health insurance and access to care. And after some years, just as it is now unthinkable that most elderly Americans in 1966 had no health insurance, it may require effort to imagine an era when American citizens were routinely denied insurance because of preexisting conditions, had their insurance canceled because they or their children got sick, or went bankrupt from six-digit medical bills. By then, one can only hope that the Washington pundits will have moved on to another real or imagined crisis.

Dr. Andrew Calman practices ophthalmology at CPMC-St. Lukes and teaches at CPMC and UCSF. He is past president of the California Academy of Eye Physicians and Surgeons, chair of the SFMS's Political Action Committee, and has for many years on California's Medicare Carrier Advisory Committee as well as the National Health Policy Committee of the American Academy of Ophthalmology. Steve Heilig, MPH, is associate executive director of public health and education for the SFMS.

INTRODUCING OUR 2014 PRESIDENT

Q&A with Lawrence Cheung, MD

Dr. Lawrence Cheung was born in Hong Kong and grew up in New Jersey. He holds a BA in biochemistry from Harvard University and an MD from Columbia University. Prior to developing an interest in dermatology, he studied internal medicine at UCSF. Dr. Cheung was a research fellow at the UCSF Psoriasis Center, where he focused his research on psoriasis, atopic dermatitis, and phototherapy. Subsequently, he completed his dermatology residency at Washington University in Saint Louis and was later the chief resident.

Dr. Cheung is currently in a solo dermatology practice with a phototherapy and laser center in San Francisco that focuses on medical dermatology. In his spare time, he runs the dermatology service at Oakland-based Asian Health Services and is actively working on implementing teledermatology in order to increase dermatology access to underserved populations.

Dr. Cheung has worn many hats for SFMS over the years and is looking forward to adding a "presidential hat" to his stack. He sat down with SFMS to share his viewpoints about organized medicine.

Why are you a member of SFMS and why is being an active member in organized medicine important for your patient-care philosophy?

I have been involved with organized medicine since my first year of medical school at Columbia University. At that time, I felt that there were a lot of health disparity issues affecting Asian Americans, and I wanted to make a meaningful and sustainable impact. Eventually a group of us from the Mid-Atlantic and New England states formed the Asian Pacific American Medical Students Association (APAMSA) to work on these issues. I am honored to have served as the first full-term national president. I am proud that the APAMSA organization has a healthy membership base in a majority of medical schools and continues to work on health care issues relevant to the Asian/Pacific Island population.

I view my involvement with SFMS along the same vein, in that I feel that there are a lot of health issues affecting San Francisco and California that should be addressed. One example is the sugar beverage tax in San Francisco, proposed by Supervisors Scott Wiener and Eric Mar. SFMS and CMA are solidly behind any efforts to decrease sugar beverage consumption in our population in order to reduce the negative health consequences of these beverages. That is just one of many issues that SFMS is working on this year.

Can you tell us about any goal(s) you hope to accomplish in your new position as SFMS President?

My goal as the SFMS president is to help make the organization more relevant to our current members and to the next generation of physicians. My work was cut out for me after a strategic retreat in October 2013. We will be working on several long-term goals that I will discuss in more detail when the specifics are finalized. Please stay tuned!

What are some of the biggest opportunities or challenges you see in health care within the next year?

I view all challenges as opportunities. In the case of our profession, it is the very core of how medical care is delivered. With the Affordable Care Act coming into effect this year, SFMS and CMA will continue to monitor how some of these changes will be implemented. I believe that we have a historic opportunity to affect some of these changes. By becoming involved with organized medicine, we strengthen our voices as physicians and our profession will have a seat on the table. If we fail to participate, these changes will be implemented without our input.

How do you balance your work and personal life, and still manage to find time to participate in SFMS activities?

I am very fortunate that I have a very supportive wife (who is a primary care pediatrician) and five-year-old twins, a boy and a girl, who remind me daily where my real priorities lie. In addition, I am in solo private practice, which also allows me the flexibility to tailor my schedule to my needs. At the end of the day, I think that everyone is busy and that one must actively carve out time to do what one values most. I have to admit that as a result, I haven't really budgeted time to work out in the past couple of years!

Any advice for new physicians transitioning into practice from residency?

My advice for young physicians graduating from residency is to join the local medical society. I believe that the medical society provides a focal point for a young physician's career. Early in one's career, it provides camaraderie and a wealth of resources for a burgeoning practice. In a mature practice, the medical society continues to provide opportunities for mentorship, volunteering, and public health policy.

What about you would surprise our members?

I love cooking and singing. I cook almost all the meals for my family, which is a great excuse for me to take a break from the twins when they are throwing their tantrums! As for music, I sing bass and I love a cappella. I performed mostly Renaissance music in college when I was in the Harvard Glee Club and doo-wop when I was in the Columbia Ultrasounds (yeah, can't you tell it was a med school group?). My five seconds of fame was when we, the Ultrasounds, performed for Good Morning America. If we had YouTube back then, we would have gone viral!

If you weren't a physician, what profession would you most like to try?

If I were not fortunate enough to practice dermatology, I would have pursued a career in public health policy. As individual physicians, we are tasked with taking care of individual patients. In establishing sound public health policy, one can influence the health of an entire population. I suppose that working with the SFMS is a way for me to dabble in this alternate career!

PRESIDENT'S MESSAGE

Lawrence Cheung, MD

Moving the Medical Society Forward in 2014

It is a tremendous honor for me to serve as the San Francisco Medical Society president for 2014. I started my solo dermatology practice in San Francisco immediately after finishing residency in 2005. I am thankful that the San Francisco Medical Society has been an invaluable resource for me since the beginning of my practice.

My most important goal will be to ensure that the Society will be relevant to the next generation of members.

In looking back, the health care landscape has undergone significant changes in past decade. For example, the electronic health record system has become mainstream, health information technology has migrated from the desktop to the smartphone, and health maintenance organizations as well as foundations are playing an increasing role in the delivery of health care in San Francisco. In looking forward, 2014 is shaping up to be a pivotal year of tremendous challenges and opportunities for San Francisco physicians and for the Society.

Dr. Cheung and his wife, Angela Wong, at the SFMS Annual Gala

This year will be the first year in which the Affordable Care Act (ACA) will be in effect. For better or worse, this will represent a new era in how individuals in America will be able to purchase health insurance. The ACA will have a profound impact not only on patients but on physicians and the entire health care delivery system. The San Francisco Medical Society has already held seminars on helping physicians understand the impact of Covered California on their patients. In the upcoming months, the Society will hold several seminars on helping physicians understand the impact of Covered California on our practices. In these rapidly changing times, the Society is as committed as ever to helping San Francisco physicians deliver the highest-quality medical care to our patients in the most professionally gratifying manner.

The Society is not only reacting to the current changes but is proactively undergoing significant realignment to stay relevant to our generation of physician members. In the fall of 2013, our esteemed past president Dr. Shannon Udovic-Constant convened a small group comprised of members from the Board of Directors and the Society staff to participate in a strategic planning retreat. A new mission statement was drafted and a vision for the future was set in place for the very first time. Most important, long-term goals to determine the direction of the society for the next three to five years were discussed. These goals are centered on developing professional resources for our members, advocating for better health care on behalf of our community, and engaging in collaborative community endeavors. Over the course of next several years, these goals will be focused and refined, and activities to achieve these goals will be set in motion.

The San Francisco Medical Society has a long and storied history. This Society has always been and will always be an organization of physicians, for physicians. As did my predecessors, I take the responsibility of serving as the president with great humility and with great responsibility. I have made it a personal priority to understand and respond to our members' needs. I am always interested in hearing from our members about ideas they have about ways that the Society can be of a greater service to us all. But I am especially interested in hearing from our future members (medical students, residents, and practicing physicians who have yet to see the importance or benefits of membership) as to how the Society can evolve to serve their needs. I hope that as the Society actively realigns to the needs of current and future members, it will continue to stay as relevant as it has for the past 146 years.

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GUEST EDITORIAL

Arthur Chen, MD

The Meaning of "Cultural Competence"

This issue explores a fuller meaning of "cultural competence," a term with origins in the 1980s. I first heard it used by the late Evelyn Lee, EdD, former UCSF professor of psychiatry and director of Richmond Area Multi-Services (RAMS). She felt compelled to define a skill set necessary to address the special cultural-linguistic needs of the patients she cared for on what was then called the Asian Focus Psychiatric Inpatient Unit at SFGH.

We now understand a broader meaning of this concept. As noted by Drs. Nwando Olayiwola and Kerry Kay, cultural competence cannot be packaged into a single training event that renders one skillfully able to handle the belief systems and values of any patient we encounter. Rather, as with any other complex specialty, it requires a continuum of experiences, mistakes, successes, exploration, and testing of tools and strategies to build a nonjudgmental, respectful, and thoughtful partnership that involves both parties in the common goal of achieving better health.

Adding depth to our understanding of cultural competence is the concept of "cultural humility," coined by Drs. Tervalon and Murray-Garcia, which emphasizes building self-awareness among providers regarding our own assumptions and belief systems and successfully managing them. Dr. Kay is clear that our health care system and approach is not always the only or even the right way. He advises asking our patients questions when we don't understand. Dr. Arthur Kleinman, in his classic article "Culture, Illness and Care," (*Annals of IM*, 1978), proposed the following questions to test differences in belief systems: What do you think has caused your problem? Why do you think it started when it did? What do you think your sickness does to you? How does it work? How severe is your sickness? Will it have a short or long course? What kind of treatment do you think you should receive?

As this issue of *San Francisco Medicine* makes clear, Bay Area patients come with myriad challenges stemming from poverty, food insecurity, substance use/abuse, mental illness, suicide, domestic violence, historical trauma, PTSD, social isolation, intergenerational conflicts, and commercial sexual exploitation, plus chronic disease and such geriatric challenges as urinary incontinence, cognitive impairment/dementia, recurring falls, and polypharmacy. Add differing belief systems and language barriers to health knowledge and the delivery of health care, and one quickly realizes how daunting medical practice and healing can be. Is it any wonder that many doctors opt out of primary care careers and head for specialties where at least some limits can be applied to the types of patients encountered?

Gearing our health care system to provide high-quality, culturally sensitive care is fraught with complexities. These range from cultural competency training to workforce development, payment structure, productivity demands, and systems that seldom allow the time to build effective patient-provider relationships. That, however, is the key to successfully negotiating through differences and agreeing on plans to achieve better health.

"Every system is perfectly designed to achieve exactly the results it gets." So said Dr. Don Berwick, past president and CEO of the Institute for Healthcare Improvement and the past administrator of the Center for Medicare and Medicaid Services (CMS).

Adopting this logic, one would have to conclude that our system was not designed to provide excellent care to a multicultural population. However, we in the Bay Area are among the nation's policy and system innovators. Our guest authors share but a few examples of the many excellent local models of practice. Clínica Esperanza incorporates data within a multidisciplinary team-based approach to improve outcomes for Latino LGBT HIV/AIDS patients. Native American Health Center provides culturally specific events that ease patients toward healthier behaviors (e.g., drum practice for middle-aged native Indian males instead of referrals to weight-management counseling). Asian Health Services' Geriatric Center of Excellence interdisciplinary teams use culture and language concordance, data-tracking registries, individual coaching, and panel management. Their youth program, in collaboration with community partners, has broken through trust barriers with youth at risk for commercial sexual exploitation. They are addressing both clinical needs and policy change needs.

Contemporary multicultural health knowledge and effective strategies have been evolving for at least the last thirty years. Reaching this stage has not been easy, and we have a long way to go. Even with ongoing training and support, it simply takes more time (e.g., engaging interpreters, social workers, listening to understand differences, and negotiating diagnostic or treatment plans) for health care professionals to develop effective cross-cultural relationships with our patients. This runs contrary to productivity demands and payment structures in health care. Yet the quality of the physician-patient relationship is absolutely essential, certainly in multicultural communities.

We must continually push for supportive policies and embed best culturally competent practices in mainstream health care delivery settings. This won't happen by itself. We need to engage our patients, coworkers, and colleagues to build on the progress of the last several decades. This is how we have gotten where we are. This is how we must continue to strive for progress in serving diverse populations—as a team, as part of a movement.

Arthur Chen, MD, is a senior fellow of family medicine for Asian Health Services and an advisor and coach for the National Leadership Academy for the Public's Health in Oakland, California.

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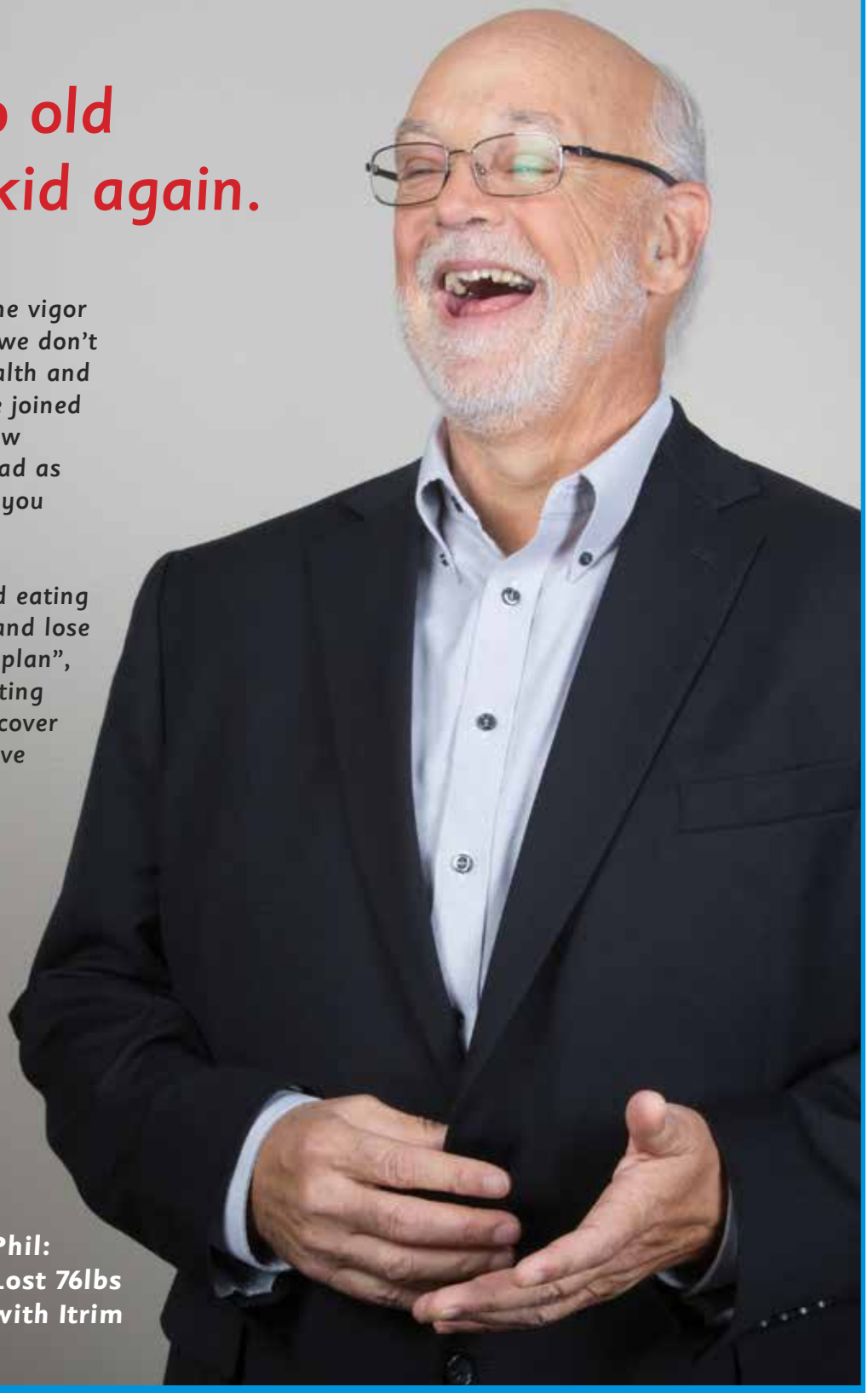

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ACULTURAL COMPETENCY

What I Did Not Learn in Medical School, Residency, or the Real World

J.N. Olayiwola, MD, MPH, FAAFP

The last thing I wanted to do that day was sit next to a homeless person on the BART, leaving San Francisco General Hospital, where I work and practice. I had new articles I wanted to read and evidence I wanted to analyze, in my quest to be continually enlightened in my field. I had no idea that this encounter would be more enlightening than many of the courses I have had in cultural competency for the last fifteen years along my sojourn from medical school at Ohio State University, family medicine residency at Columbia Presbyterian, fellowship and master's education at the Harvard School of Public Health, practice and leadership at a large federally qualified health center in Connecticut, to my current position at UCSF in the Department of Family and Community Medicine.

"Is anyone sitting here, ma'am?" There I was, with that open seat beside me, and this person wanted it—I had no choice but to let them sit down. I say "person" because the features were neither masculine nor feminine (I would have believed either), neither young nor old (I would have been convinced if I heard age twenty-five or sixty-five), not uniquely belonging to any ethnic group (Asian, African, Hispanic, Caucasian would have all been appropriate given the unkempt and ashen appearance), not geographically suggestive (could have been an East Coaster, West Coaster, from Middle America, an immigrant, or none of these). So when the person looked at my iPad screensaver picture and said, "Are those your children?" I was curious why they cared.

"Yes, they are," I replied.

"They are beautiful. My children don't care about me at all. I wish they were still that age when they loved their mom. Hold onto them. Cherish this time."

Now I had to know more. "You have children? How old are they?"

"Twenty-five and twenty-nine. They live in Seattle. They don't care about me anymore."

"I am sorry," I said. "I cannot even imagine. Are you. . . ?" I couldn't say it. Nor could I fathom how a woman with two grown children could end up on the streets of San Francisco alone.

"Homeless? Yes, I am. It's so embarrassing."

We entered into a very deep conversation, in which I discovered that she had been a victim of domestic violence for her entire life, first witnessing it as a child in an abusive home, then being a victim of a series of failed heterosexual marriages and relationships. She and her kids lived in various domestic violence shelters and, somewhere along her journey, she felt that she was a lesbian. She then entered into a few abusive homosexual relationships where she was again victimized by her partners. She then felt that she was homosexual and heterosexual, but adamantly not bisexual, and while I really struggled to understand how she drew the distinction, she had perfect clarity on it. She called herself a Catholic but did not feel she fit the profile anymore. She had dabbled in other religions when her kids were small but was now a "Catholic agnostic." Her parents were in Central America and wanted nothing to do with her, feeling that she had made a series of bad decisions that jeopardized her children and shamed their family. Her children grew up and were so resentful of her past that they left California and moved away from her, severing all ties. She never finished high school but called herself an "educated illiterate," stating she learned a lot from her life, but she did not have good basic reading and writing skills. She had worked some odd jobs cleaning houses and offices for a couple of years but could not pay the bills, and finally ended up homeless and destitute. She stated that she was not a "beggar," but that she "asked" people for things she needed, like money to take the BART that day.

As I spoke with her, I realized that she could have easily been any of my patients. So I asked her about her health and whether she had a doctor. She said her health was not that great, but that she did not have a doctor because "doctors are always judging me. They want me to tell them everything straight, but nothing is straight to me. I am a confused soul. I'm pretty much everything, and pretty much nothing at the same time."

I thought of all of the cultural competency training I have been fortunate to have and yet how unprepared I was for this interaction.

I remembered the "culturally appropriate" social history questions I learned to ask a patient like her, and how those and the demographic questions on standard patient questionnaires would have missed a lot of who she was. This was a middle-aged woman with Irish, French, and Nicaraguan blood; raised in different parts of the United States and Central America; homosexual and heterosexual at the same time; Catholic and agnostic; a mother but without contact with her children; a victim of domestic violence since her earliest days; and a self-proclaimed "educated illiterate." Which "culture" would I identify with to dictate the formality or informality of a doctor-patient interaction with her? Would I have avoided staring her in the eyes or giving her a hug? Would I have called her by her first name or called her Ms. Something? Would I speak at a fourth-grade reading level or a twelfth-grade one?

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Acultural Competency

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Would she prefer to speak in English or Spanish? Would I assume she deferred to doctors or that she wanted a partnership for her care? Would I advise her to change her diet but in a way that respected her culture? Which of my personal biases and beliefs would be challenged by a patient like her?

I realized that I did not know how I would have handled a patient like her, because, in essence, she was "acultural"—she did not adopt the identity, beliefs, or characteristics of any of her components or groups; she did not fit into any particular box; and some of the cultural competence skills I had learned would have both encouraged and offended her at the same time. It was an enlightening moment.

Medical education encourages cultural competency as a skill set needed to care for patients of diverse backgrounds, and to aptly and nonjudgmentally apply these skills to reduce stigma, bias, and the antagonism of our personal beliefs with a patient's beliefs. This education is often in the form of particular curricular insertions in early medical school education, hospital and residency orientations, human resource trainings for staff, and, in some states, required ongoing continuing medical education credits (CME) for physicians and other professionals. The process of instilling this knowledge is often a singular curricular event as opposed to a longitudinal experience. In my previous practice setting, all staff completed an online HealthStream module on cultural competency, amid modules for ergonomic safety, family violence, environmental hazards, hand washing, stages of development, and others. This was completed at orientation and annually, and the measure of understanding was completion of the module, not application to the practice environment and patient population. While I saw many examples of my physician colleagues who were blatantly "culturally incompetent," I have never quite learned what "fully culturally competent" looks like. Is it attainable? Is it measurable? Is it transferable? Do patients know it when they see it? Would I know it if I saw it? Does it change depending on the circumstances? Is it all or nothing?

While it is incredibly impressive that cultural competency has penetrated what is often an impermeable medical education system, this patient shifted my thinking about this area a great deal. Cultural competency is really not a course but a continuum. It is not sufficient for it to be "taught." It must also be "learned," and the learning process must be ongoing and protracted, iterative, fluid, and circumstantial. Physician learners should have the forum to share experiences, how they learned from them, what they did wrong, and what they did right. Tools and strategies for handling diverse encounters should be explored, and less emphasis should be placed on the specific "to do's" and "not to do's" that exist in many current programs. Leaders in the field of cultural competence in health care can take the helm in preparing future and current physicians to handle the "acultural" patient who does not fit into any specific culture and who says, "I'm pretty much everything, and pretty much nothing at the same time."

As I learned that day, that patient is probably much closer to us than we know or think. I may not ever see her again, but I hope she will realize the impact she had on me and how, on that brief BART ride, she shattered many of my notions of culture. I never got to do that reading on the train, but I learned more than I had ever planned.

Dr. J.N. Nwando Olayiwola is a family physician, the associate director of the Center for Excellence in Primary Care, and assistant professor in the Department of Family and Community Medicine at UCSF. Her role is to support the Center in achieving strategic objectives around primary care transformation and systems redesign regionally, nationally, and internationally. Prior to this, Dr. Olayiwola served as the chief medical officer at the largest FQHC in Connecticut. She has been a leader in harnessing technology to increase access to care for underserved populations and is an expert in the areas of health disparities and primary care redesign. She completed her residency in family medicine at Columbia University, where she was a chief resident. She received her MPH in health policy from the Harvard School of Public Health as a Commonwealth Fund Fellow and Presidential Scholar.

DOCTORS IN RECOVERY

The San Francisco Caduceus Group

This group is a weekly no-fee discussion group connected with IDAA (International Doctors in AA). The meetings are open to anyone in recovery from chemical dependency who has a doctoral-level degree in health care. This includes physicians, dentists, veterinarians, psychologists, and pharmacists. The group meets each Thursday at 7:30 p.m. at Kaiser French room 411A at 4141 Geary Blvd., San Francisco. The parking lot entrance is on 4th Ave between Geary and Anza. The contact person for the group is Dr. John, who can be reached at (415) 987-0327 or by email red415@gmail.com.

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CLINICA ESPERANZA

Building a Culture of Healing at the Mission Neighborhood Health Center

Shaddai Martinez-Cuestas, MPH, and Joanna Eveland, MS, MD

On December 5, 2013, Clínica Esperanza's patients, staff, and supporters gathered at the Mission Cultural Center to celebrate World AIDS Day with art and music. At this annual event, each colorful handcrafted mask lining the walls provided a vehicle for a patient or staff member to tell their story. Amid the laughter, songs, and remembrances of our shared history, the Clínica Esperanza community spirit shone as brightly as the candles on our altar. As one patient put it, "This staff loves 'us.' Now that I have experienced this, I understand the profoundly positive effect it has on my health. Nothing else will do." (2012 Clínica Esperanza Patient Satisfaction Survey)

Founded in 1989, Clínica Esperanza (Clinic of Hope) provides a wide range of services to approximately 400 HIV+ patients each year. Clínica Esperanza was the first clinic to offer specialized HIV care to monolingual Spanish speakers in San Francisco, providing collocated medical and social services. Using an innovative multidisciplinary model, Clínica Esperanza has earned the attention and respect of public health officials at the local and national levels.

Clínica Esperanza serves a unique population. Seventy-five percent of our patients are Latino, 88 percent are male, 73 percent identify as gay, and 6 percent are transgender. (2012 demographic data) While some of their issues are common to other underserved communities—poverty, food insecurity, substance abuse, and, ever more common in San Francisco, lack of access to affordable housing—they also face distinctive challenges. As Dr. Rafael Diaz describes in his book *Latino Gay Men and HIV*, the patients we serve "retain strong ties to their families and the straight Latino community, often at the price of silence about their lives and a sense of personal isolation and alienation." (*Latino Gay Men and HIV*, p. 155) This isolation has profound effects on the health of our patients—as evidenced by the fact that about 40 percent have a psychiatric diagnosis. It is only through working as a culturally diverse multidisciplinary team, with a focus on building a healing community within the walls of our clinic, that we can reach this high-risk group.

Latinos have been disproportionally affected by the HIV epidemic in the U.S. The HIV diagnosis rate for Latino males is approximately three times that for white males. Latinos present later to care and are more likely than whites to die earlier from AIDS. (National HIV/AIDS Strategy, 2010 and CDC 2011 data) Our success working with this population is demonstrated by outstanding clinical outcomes that stand in stark contrast to regional and national data. At last measurement, 93 percent of our patients were retained in care, 94 percent were prescribed antiretroviral therapy, and 89 percent of our clients maintained suppression of their HIV virus. (October 2013 data) We identify three elements as key to our success: our commitment to cultural competence, a team-based model of care, and a data-driven approach to improving outcomes.

Cultural competence comes partly from building a care team that mirrors the community we serve. Nahum Neme, a former Clínica Esperanza patient who now works as Peer Advocate, describes the clinic community: "I have met wonderful people like my friends and coworkers at Clínica Esperanza, who have supported me unconditionally and have seen my transition from patient to employee, being part of one of the best teams, working to ensure that people with HIV have a better quality of life and that HIV negative individuals continue staying negative." A bilingual and bicultural staff facilitates entry into care for Latino patients, especially monolingual Spanish speakers and recent immigrants.

Including the entire team in our care is crucial to successful patient engagement. There is a deep appreciation that movement along the stages of change is rooted in close relationships with staff, and often with nonmedical staff who have more time to develop such relationships. While our cost of care per patient is comparable to similar clinics, we have a high ratio of social services staff to medical staff. We commit to weekly interdisciplinary meetings to review full patient histories and the most appropriate interventions. These team meetings include the entire staff, from provider to nutritionist to medical assistant to front-desk staff. This ensures seamless communication among staff, which translates into seamless service delivery. As our Clinic Manager Virginia Scribner puts it, "Making medical care, education, and case management support more accessible to all in need is part of what I like to call Clínica culture; that was there in the beginning and is still a motivating principle." A core philosophy of our medication adherence program has been to emphasize a patient readiness model as opposed to a "test and treat" approach.

Underlying our vision for patient empowerment is a dynamic Quality Improvement program focused on clinical outcomes. With our transition to electronic health records, we have been able to improve outcomes for our most vulnerable patients by implementing tracking systems. We use the data to prioritize and tailor our interventions in an effective way. These systems allow us to easily identify which patients have difficulties staying in care and in maintaining an undetectable viral load. We discuss this data with the entire team, which facilitates communication and concerted interventions.

As we continue to seek ways to build community within the clinic, Clínica Esperanza has embraced creative strategies to engage our patients in the narrative of their care. When patients

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Clínica Esperanza

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failed to attend a traditional HIV support group, it was redesigned as a knitting group, now expanded to explore other arts and crafts, where patients teach, learn, and create together. Our annual mask-making workshop series culminates in an exhibit at a local art gallery, as described above. As Scribner describes our experience, "We get to know the patients quite well, and they've gotten know us, and for some, Clínica is family. Our patients are talented and creative. We get to see what they've done and join in the creative process as well." The therapeutic nature of these activities not only helps our clients individually but also fosters a sense of belonging and connection—a cure for isolation that translates into healthy individuals and a healthy community. In our twenty-fifth year, we look forward to continuing to build our Clínica Esperanza "familia," a welcoming medical home for people living with HIV.

Shaddai Martinez-Cuestas is the director of HIV Prevention and Wellness and Joanna Eveland is the HIV Clinical Coordinator at the Mission Neighborhood Health Center.

NATIVE AMERICAN HEALTH CENTER

Cultural Aspects of Care

Sandra Tavel

"Cultural Humility: A lifelong process of self-reflection and self-critique. The starting point for such an approach is not an examination of the client's belief system but rather having health care/service providers give careful consideration to their assumptions and beliefs that are embedded in their own understandings and goals of their encounter with the client."—Dr. Melanie Tervalon and Jann Murray-Garcia

Native American Health Center, Inc. (NAHC), is a community clinic that serves approximately 12,000 patients per year and offers medical, dental, behavioral health, and WIC services to American Indians and Alaska Natives, as well as anyone who is uninsured or has Medi-Cal in the five-county San Francisco Bay Area. There are no tribal or ethnic requirements to become a patient at NAHC. Since its inception in 1972, NAHC has seen its patient/client population change, but it has always been diverse. There are 468 federally recognized tribes in the United States. American Indians and Alaska Natives from all nations came to the San Francisco Bay Area from 1952 to 1972 under the federal relocation program that courted young, single people living on reservations to move to major urban areas to assimilate into mainstream society. The government promised housing, jobs, and education and delivered on its agreements inconsistently enough to leave a large population in an unfamiliar place to fend for itself. That's how NAHC began—as a response to injustices that called for basic rights for American Indians and Alaska Natives. NAHC has always moved from the belief that health care is a basic human right and not a privilege.

NAHC offers American Indian, culturally specific programs and activities for American Indians living in the area, as well as health services, to a wide array of patients and clients from all races, ethnicities, and cultures, as they reflect the surrounding neighborhoods and communities in which our sites are housed. We are unique because we aren't an IHS (Indian Health Service) clinic and we serve everyone. The first thing one could notice when walking into our clinics is just how diverse our staff is—they reflect the community we serve. Our chief health officer, Dr. Linda Aranaydo, is Muscogee-Creek and Filipina. She grew up in Oakland and started at NAHC as a medical assistant. She put herself through medical school, worked in her homeland in Oklahoma, and returned to the Bay Area to work for NAHC. Many of our licensed medical and dental providers also have an MPH, which speaks to their commitment to community health. Our associate medical director, Dr. Fumi Suzuki, calls community health the last arena where we can affect social justice. Many of her colleagues share that sentiment. A diverse workforce is certainly part of cultural competence, but what exactly does the term even mean?

Sandy White Hawk, a Sincagu Lakota woman committed to rehabilitating the foster care system for American Indian children and families, taught a class on cultural competence that was funded by the California Endowment a year or two ago. She said, "'Cultural competence' is a fancy term that someone made up while they were writing a grant." She proposed that the idea of cultural competence feels daunting because it makes us feel as if we must be proficient and already know cultural nuances for everyone we meet who is different from us. Instead, we should cultivate the skills to listen respectfully to what our clients value; have a deep understanding of our own values and triggers; and self-manage ourselves to the point that our patients and clients feel heard, seen, and respected: cultural humility.

One of the ways NAHC informs this concept is that all existing and new employees are taught about American Indians in the Bay Area—how they got here, the history behind relocation and NAHC's response to it, historical trauma, and cultural humility. This teaching is part of all new-hire orientations and there is always a cultural aspect discussed when NAHC hosts large meetings or trainings for staff. The American Indian population within NAHC's patient base experiences the same health issues as other disenfranchised communities: type II diabetes, substance use/abuse, domestic violence, suicide, and poverty. NAHC has always offered "wraparound" care that addresses the health of the entire individual instead of treating single symptoms and issues in isolation. In addition to offering holistic care, NAHC addresses cultural aspects by connecting American Indian patients to a culturally specific event and easing the point of entry into medical care from there. In many cases, it's more palatable for a middle-aged, American Indian man to attend drum practice than it is for him to come in and receive counseling on weight management or smoking cessation. The latter items are certainly important—but so is the point of entry. NAHC has connected many of its patients and clients to cultural aspects that have brought them closer to consistent medical care. We have conducted naming ceremonies for babies in the community; hosted a "Wiping of the Tears" ceremony facilitated by a traditional consultant that dealt with the impact historical trauma has had on most of our patients; and hosted weekly traditional arts classes at no cost to the participants—just to name a few. NAHC's contention is that if we can ease our patients into care by offering the peer support and encouragement that happens in culturally specific groups, we may have higher success rates of patients staying engaged in care. NAHC also believes that if we set an expectation for all staff to know their own values and triggers and to self-manage to the point that all clients and patients feel seen, heard, and respected, then we are following our mission to serve those for whom mainstream systems of care do not work.

Sandra Tavel is grants and contracts administrator at NAHC. For more information, please visit www.nativehealth.org.

GERIATRIC CARE

The Changing Face of Geriatric Care in the AAPI community

Susan Huang, MD, MS, and Thu Quach, PhD, MPH

The elderly population in the U.S. has grown significantly, increasing at a faster rate (15 percent) than the general population (10 percent) between 2000 and 2010.[1] California has the highest number of seniors in the nation. Among seniors nationally, minorities constitute the fastest-growing population groups. In fact, the Asian-American and Pacific Islander (AAPI) older population has increased by 145 percent during the last decade, and California currently has the most AAPI seniors compared to other states.[2] In California's Alameda County alone, there are more than 44,500 AAPI seniors.[3]

The AAPI population in the U.S. embodies more than forty-nine ethnicities and 100 languages, with two-thirds foreign born[4] and thus highly diverse in culture, language, and health needs. Many underserved AAPIs often lack the financial resources and the linguistic and cultural skills necessary to access early diagnosis and comprehensive treatment for their health problems.[5]

Despite these rapidly changing demographic trends, the medical community in the U.S. has been slow to adapt and is ill prepared for the cultural and linguistic diversity of our aging populations. Traditional medicine and traditional health care models have centered on the management of specific chronic conditions, such as diabetes and high blood pressure. The needs of older adults and their complex syndromes do not often fall neatly into well-defined individual disease categories. The complexities of key geriatric syndromes such as falls, urinary incontinence, cognitive impairment/dementia, and polypharmacy require a care model that can more comprehensively coordinate and address care needs at multiple levels. In addition, there is an urgent need for workforce development and skills building in order to meet the rising health care demands of the rapidly growing population of older adults in the U.S., and training programs have traditionally lagged in geriatrics care training. The shifting demographics and diversity of U.S. seniors further require that providers and health care systems understand and embody cultural and linguistic competencies to effectively care for these older adults.

According to the Robert Wood Johnson Foundation, three out of four adults over the age of sixty-five have multiple chronic conditions. Seniors with multi-morbid conditions often suffer worse quality of life with higher rates of adverse events, disability, institutionalization, and death. Several key geriatric syndromes are prevalent and significantly impact older adults in terms of quality of life and functional status. For example, nearly one-third of adults sixty-five years or older fall each year, and the rate increases to 50 percent in those over eighty years of age.[3] Approximately 10 to 15 percent of these falls result in major injuries such as fractures and brain injury, requiring hospitalization. In many cases, seniors must remain in costly long-term care facilities for extended periods. The cost of falls is significant to the U.S. health care system.

Cognitive impairment and dementia are also growing health concerns for the senior population. Rates of Alzheimer's disease are expected to quadruple in the next fifty years.[4] Studies have demonstrated the prevalence of dementia in minority populations, including AAPIs, to be higher than that of non-Hispanic whites. Dementia significantly impacts an older person's behavioral health and self-care capacity, and it presents significant caregiving challenges to families. Urinary incontinence, a potentially reversible condition, is an underreported and often undetected condition among older adults, especially women. Its adverse effects can be profound and are associated with increased social isolation, mood disorders, falls, and fractures. Finally, the older population is particularly at risk for the adverse effects of multiple coadministered medications, or "polypharmacy." Medication side effects and potential cross-interactions can exacerbate functional decline, malnutrition, and other syndromes such as falls, urinary incontinence, and cognitive impairment.

For AAPI immigrant elderly, the impact of geriatric conditions is often further magnified by a multiplicity of socioeconomic factors, including low-income status, limited English proficiency, cultural differences, and low health literacy.

In general, AAPI older immigrant adults face a triple jeopardy on their health, given their advanced age, minority status, and social and linguistic challenges.

Started in 1974, Asian Health Services (AHS) is a federally qualified community health center in Alameda County, California, serving more than 24,000 patients in more than 114,000 patient visits a year. Providing services in English and eleven different Asian languages, AHS' mission is to serve and advocate for the medically underserved, including immigrant and refugee AAPIs.

With nearly 5,000 AAPI older patients, AHS serves a significant proportion of the AAPI elderly population in Alameda County. AHS' older patients constitute over 20 percent of AHS' patient population, a much higher percentage than the average 6.9 percent senior population in other community health centers nationwide.[5] Responding to the complex and diverse health needs of its elderly patients, AHS opened its Adult Medical Services at the Hotel Oakland (AMSHO) clinic site in 1997.

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REFRAMING OUR RESPONSE

A New Approach to Care for Commercially Sexually Exploited Children

Kimberly Chang, MD; Elizabeth Sy; Thien Vo, NP; Suzanne Nguyen, MD; Manith Thaing; Jennifer Lee, MPH; Thu Quach, MPH, PhD

It has been estimated that approximately 300,000 children under the age of eighteen are at risk of becoming commercially sexually exploited victims within the United States.[1] Sexual exploitation of children is the most hidden form of child abuse and has reached epidemic proportions.[2] Many commercially sexually exploited children (CSEC) have a history of victimization, including physical and sexual abuse, home violence, and homelessness[1]. The underground and transient nature of sexual exploitation has contributed to a lack of understanding among service providers and law enforcement. Coupled with complex psychological factors involved in exploitation, identifying CSEC becomes a tremendous challenge.[2]

An increasing number of Asian teens, particularly Southeast Asians (SEA), are at risk for commercial sexual exploitation. SEAs include refugees and immigrants from Cambodia, Laos, Thailand, and Vietnam. Many SEA youth are at risk due to multiple factors, including high rates of poverty and cultural and/or intergenerational conflicts as they attempt to adjust to a U.S. lifestyle vastly different from that of their parents. A large proportion of first-generation SEA immigrants and refugees suffer traumatic effects of regional conflicts from the Vietnam War. In the Cambodian community, many families still cope with the tragedies of persecution and genocide—posttraumatic stress disorder, depression, addiction, and domestic violence. Studies indicate that 40 percent of SEA refugees suffer from depression.[3] With these home-life struggles, teens may turn to escape, often recreating themselves on the streets with their peers.

Role of Health Professionals

Asian Health Services (AHS) was founded in 1974 to address the unmet health care needs of Asian and Pacific Islanders and to advocate for improved access. Four decades later, AHS provides medical and dental services to more than 24,000 patients and is a nationally recognized comprehensive community health center model for serving a primarily low income, limited English speaking population.[4]

The issue of CSEC first emerged at AHS through its Youth Program, which provides reproductive health education to youth aged twelve to eighteen years old. As youth began learning about reproductive health, they sought out services at AHS' Teen Clinic. The Youth Program educators and providers noted that teen patients were seeking clinical care for repeated and frequent symptoms of sexually transmitted diseases and were noted to have multiple sexual partners, chronic truancy issues, a history of sexual abuse, and other risk factors for sexual exploitation. As trust built between patients and AHS staff, some patients disclosed that they were "turning tricks," prompting providers to engage in conversations about exploitation and safety. Patients started revealing the underground world of CSEC, including the numerous public advertisements in popular press advertising young Asian women for "dates." AHS staff pieced together this emerging issue, noting the vulnerability of young SEA female patients.

In 2004, in response to the rising number of sexually exploited SEA youths in the local area, AHS and other community organizers cofounded Banteay Srei, a youth-development, asset-building organization that works with young SEA women who are at risk of or engaged in the underground sex trade. The four prongs of AHS—the Teen Clinic, the Youth Program, Banteay Srei, and AHS' School-Based Health Centers—work collaboratively to identify CSEC, provide primary health care, and refer them to supportive resources. Furthermore, AHS' School-Based Health Center staff provided training to the Oakland Unified School District regarding screening and prevention services. AHS staff also raised public awareness of this issue through public presentations and sharing of their CSEC screening tool for health care providers.[5]

Recommendations

A major challenge in addressing the CSEC epidemic is the difficulty in identifying this vulnerable population. When mistakenly viewed from a lens of "personal responsibility," CSEC victims are arrested and prosecuted as criminal prostitutes, with little attention paid to the traumatic exploitation process contributing to their circumstances. Many strategies fail to facilitate healing, prevent recidivism, or encourage development. Moreover, in the early stages of exploitation, sufficient resources are not accessible to victims prior to arrest.

Reframing solution models to address CSEC from a public health prevention standpoint can align treatment needs of victims with the goals of criminal justice and other system providers. In this framework, the CSEC issue can be defined as the population-level "disease," while individual harms of exploitation, such as STIs, can be defined as the "illness". The stages of CSEC can be organized into three prevention levels (primary, secondary, and tertiary prevention), with a fourth stage of chronic treatment and support after transition out of exploitation (i.e., long-term prevention).

Primary prevention consists of population-level efforts to prevent children from becoming CSEC, including education efforts for adolescents to recognize healthy versus harmful relationships and mental health counseling to prevent them from being at greater risk for becoming CSEC. Furthermore, there can be more efforts directed toward health professionals, including continuing medical education requirements incorporating edu-

Continued on the following page . . .

Reframing Our Response
Continued from the previous page . . .

cation about screening and treating CSEC. Efforts could also focus on licensing bodies of other professions to require training on the health effects of commercial sexual exploitation.

Secondary prevention consists of methods to diagnose and treat CSEC in early stages, before significant harms or illnesses result (e.g., sexual and physical violence or unintended pregnancies). Policies mandating reporting and data collection on CSEC and requiring universal screening of adolescents at health access points, or at a criminal justice interface for any type of offense, are examples of secondary prevention measures.

Tertiary prevention consists of minimizing harms to children when commercial sexual exploitation occurs. These are current interventions like using criminal justice tools of arrest to remove children from streets, placement of children in foster care, or sexual assault response teams in the emergency rooms. Health policies could include immediate medical and mental health assessment if a child is arrested for solicitation or another offense.

Finally, a fourth stage exists when children transition out of commercial sexual exploitation. During this phase, the "disease" of CSEC may no longer exist, but long-term consequences remain (e.g., PTSD and HIV). Developing programs and policies that promote treatment for survivors could assist with long-term healing (e.g., resources for mental health treatment, housing, or education).

Viewing CSEC through a public health prevention framework could provide a comprehensive, unifying strategy to align various sectors with goals of protecting children, healing victims, and supporting survivors. The first step, of course, is to raise awareness and garner support from our health sector to view this problem as a health issue of epidemic proportions, and to approach it through the lens of prevention and intervention.

The authors work at Asian Health Services and Banteay Srei, Asian Health Services, in Oakland, California.

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Geriatric Care
Continued from page 20 . . .

This clinic site specialized in geriatric functional assessments, dementia and chronic disease management, end-of-life care, and other elderly needs assessments and referrals integrated in its primary care model. In 2013, this AMSHO site merged with AHS' newest clinic site to establish the AHS Geriatric Center of Excellence.

AHS' Geriatric Center focuses on providing patient-centered health care in which co-located, multidisciplinary health professionals and staff work collaboratively as care teams with patients and families to manage chronic conditions and geriatric syndromes and optimize care goals and quality of life. The multidisciplinary care teams include primary care providers, behavioral health professionals, nutritionists, case managers, panel managers, drug dispensary technicians, referrals coordinators, health coaches, and nurses. The center uses targeted, evidence-based screening tools and risk assessments and monitors care for syndromes such as falls, cognitive impairment/dementia, urinary incontinence, and other chronic conditions such as diabetes and hypertension. The care model includes health coaching and panel management activities in order to provide more integrated and comprehensive care to seniors than the traditional fifteen-minute in-office medical visit. The "teamlets" of health coaches, primary care provider, and ancillary care professionals employ team huddles, tracking registries, between-visit phone support, and other strategies, all with cultural and language concordance, to improve the disease self-management skills, health understanding, care coordination, and overall health of these seniors. AHS is also custom building a culturally and linguistically nuanced, evidence-based geriatrics care curriculum as a solution to promoting competencies in its geriatrics care teams.

To provide effective health care to AAPI immigrant seniors, we must recognize the myriad of vulnerabilities beyond advanced age, such as linguistic and socioeconomic barriers, that can threaten the health of these communities. Health care providers for AAPI elderly must possess not only core geriatric care skills but also cultural and linguistic competencies in order to effectively respond to the complex needs of these patients. Therefore, it is imperative that we invest in the acceleration and development of care models and skilled workforces to provide competent care to this growing segment of the population.

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CULTURAL COMPETENCY

A Personal Reflection

Kerry Kay, MD

The only thing I remember from my medical school curriculum on cultural competency is that cupping should not be confused with child abuse. In a short video that we impressionable young medical students watched, an Asian child was brought in to see her pediatrician, who finds alarming circular bruises on her back. Ah, this is just cupping, the ancient Chinese therapy of placing heated cups on the skin to improve circulation. The bruises should not be confused with child abuse. The take-home message is fuzzy for me now, ten years later. I might not be so sure what I learned from that video, but it's reliably the first thing I think of when I hear the words "cultural competency" and when I see cupping marks on my patients.

Fast-forward ten years later, I am now working at a community health center in Oakland, California, called Asian Health Services. All I do all day is see patients from cultures that are not my own. Now, an aside about my past: I am Chinese. I emigrated from Hong Kong to the U.S. when I was thirteen. I didn't go to a Chinese school growing up, so my Cantonese is passable but far from eloquent. On a typical day at work, the bulk of my patients are Cantonese-speaking immigrants from Hong Kong, Southern China, or Vietnam who speak little to no English. Interspersed during the day are English-speaking patients who live in Oakland, immigrants from Mongolia, Cambodia, Myanmar, and Karen refugees from camps in Thailand. It didn't take me long to realize the cupping video I watched in medical school wasn't going to be much help. When I don't speak the language of my patients, I am lucky to be able to turn to our interpreters for help. Our medical assistants come from the countries our patients are from. They are all certified interpreters. They translate the words of my patients and also fill in the gaps in culture that I might not be aware of.

As a doctor from Hong Kong, you might think that cultural competency with my Chinese patients isn't something I have to worry about anymore, but that hasn't been the case. My Chinese patients are not only from China. They are also from Taiwan, Vietnam, Cambodia, Myanmar. Even my patients from China are a diverse group, coming from all over the country. Just as someone from the South can be different from someone from the Midwest, my patients from the south of China are not the same as those from the north. Class, education, prior interactions with doctors, whether they are from the city versus the country—all these characteristics contribute to a cultural difference that might not be readily apparent to me. One thing they all share, however, is that they are all immigrants. As such, they all share the experience of leaving family, friends, jobs to come to the U.S. for a better life. Each immigration story is different. They could have left a better job just so they can provide better opportunities for their children. They could have immigrated to be reunited with family. These are all cultural experiences that will affect my relationship with my patients.

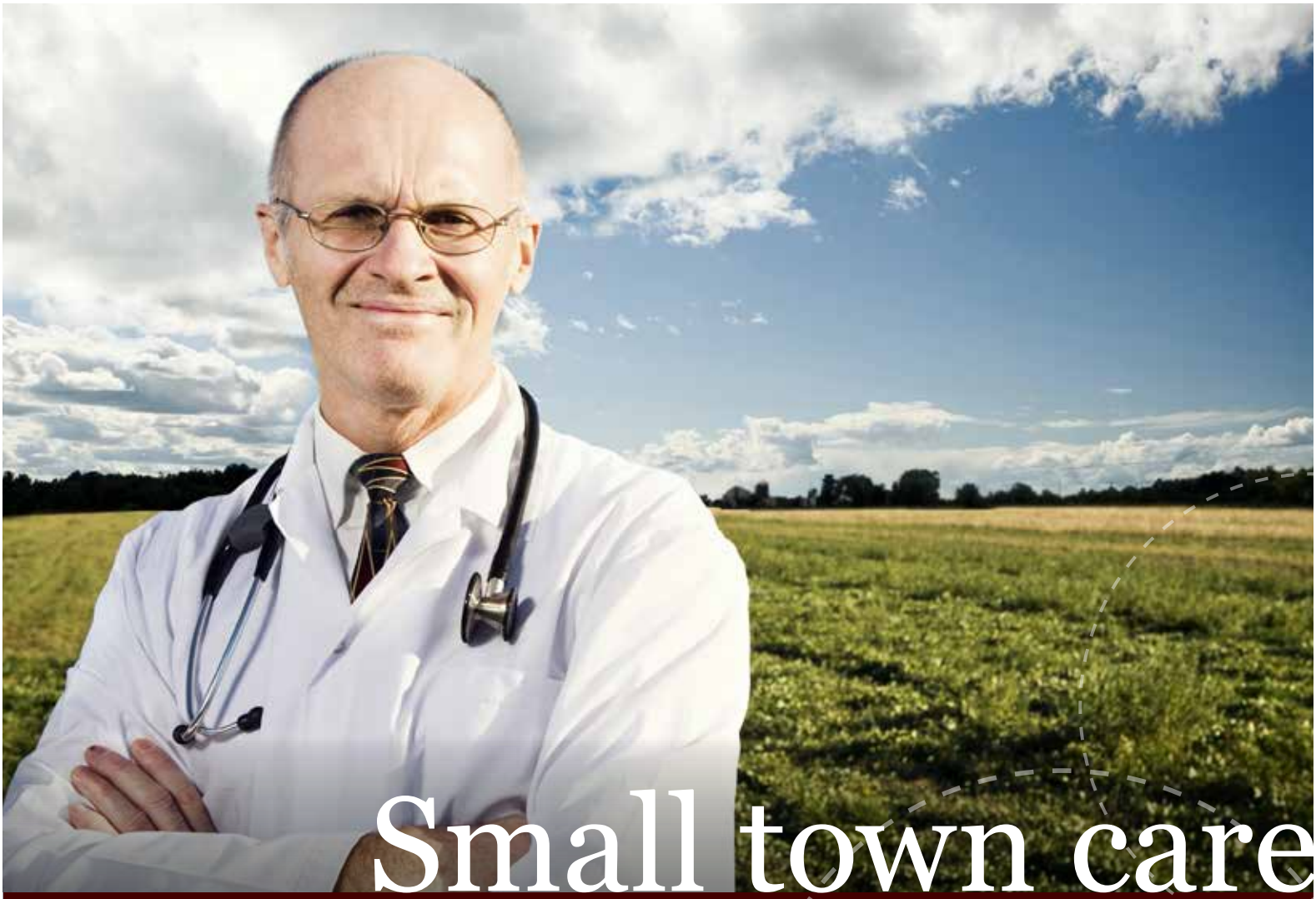
The point is that people are hard to pin down, no matter where they are from.

Sometimes the goal of cultural competency can turn into a litany of characteristics that we hope can explain a whole race of people, but ultimately this can be flawed and incomplete. In Chinese medicine, qi is the energy that flows through your body that becomes imbalanced in illness. In Chinese culture, the group is emphasized over the individual. Chinese people hate having their blood drawn because they believe it is the source of life. But the danger of memorizing a list of cultural attributes is that it boxes our patients into neat categories they can't break out of. Less than 1 percent of my patients have ever talked about qi to me. Sure, they can have a conversation about it, but that's not what they have come to me for. If I continued to talk to my patients about qi, it would be illogical and presumptuous.

I'm not saying it's not important to learn about other cultures, but what I am saying is that it'll only take you so far. The rest is the same as what we do with every patient: meet our patients where they are. Ask questions when you don't understand. Keep in mind that different cultures have different expectations of health care, and that our health care system is not the only or the right way. Cultural competency can be a foundation, but it's only through building a thoughtful and self-reflective relationship with each patient that the communication barriers that come with cultural difference can be overcome.

Working with multicultural patients has made me curious about the places my patients are from. I went to Myanmar last year, and having been there has helped me put my patients in a context that didn't exist for me before. I just watched a documentary about the end of the Vietnam War, which got me thinking about the immigration stories of my Vietnamese patients. Working with patients from all over the world is challenging, but it also makes work interesting. It's the unique opportunity given to each doctor: culture, history, life, all brought to your doorstep.

Kerry Kay is a Family Medicine physician. He works at Asian Health Services, a community health center in Oakland, California.



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HEALTH POLICY PERSPECTIVE

Stanton Glantz, PhD

The 1964 Surgeon General's Report on Tobacco

The Tobacco Companies Were Terrified—How Do We Realize Their Fears Fifty Years On?

A half century on, there is much assessment taking place of the importance of the 1964 Surgeon General's report. There is no question that the report was a landmark event that provided the weight of government behind the conclusion, already reached by the scientific community ten years earlier, that smoking caused lung cancer. The issuance of the report and the attendant public discussion did seem to stop the growth in per capita cigarette consumption.

While stopping the growth in smoking, it is worth considering what the tobacco companies were afraid would happen when the report came out. Fortunately, we know, thanks to the millions of previously secret tobacco industry documents in the UCSF Legacy Tobacco Documents Library. In a word, the companies were terrified.

In June 1963, the major tobacco companies and their public relations agency, Hill and Knowlton, held discussions about the then-anticipated Surgeon General's report. Here is a summary of the meeting:

The consensus is that the Industry is in "grave crisis," and the philosophy is "to expect the worst and work for the best." Of course the greatest cause for alarm is the forthcoming Surgeon General's Report, which is expected to be detrimental to the industry. The only degree of hope is the possibility that, instead of singling out tobacco, the report will take into account a list of other agents (environmental and otherwise) which are suspect. However, this is deemed a rather dim hope, because indications point to a strong Indictment of tobacco, with possible "root-shaking" consequences.

And while politicians and most health advocates saw the companies as invincible, they themselves saw things quite differently. The memo continues:

Thus, an unmistakable note of pessimism sounded throughout the discussions. This was further evidenced by constant references to resolutions, programs, and statements against smoking by various organizations (American Cancer Society, Heart Association, State Medical Societies, etc.). Of real concern is the mounting organized opposition, along with the extensive press coverage of antismoking reports and activities. This "stacking of the cards" against the industry is viewed with special alarm, since it conceivably can be conditioning the public to accept any detrimental aspect of the Surgeon General's Report.

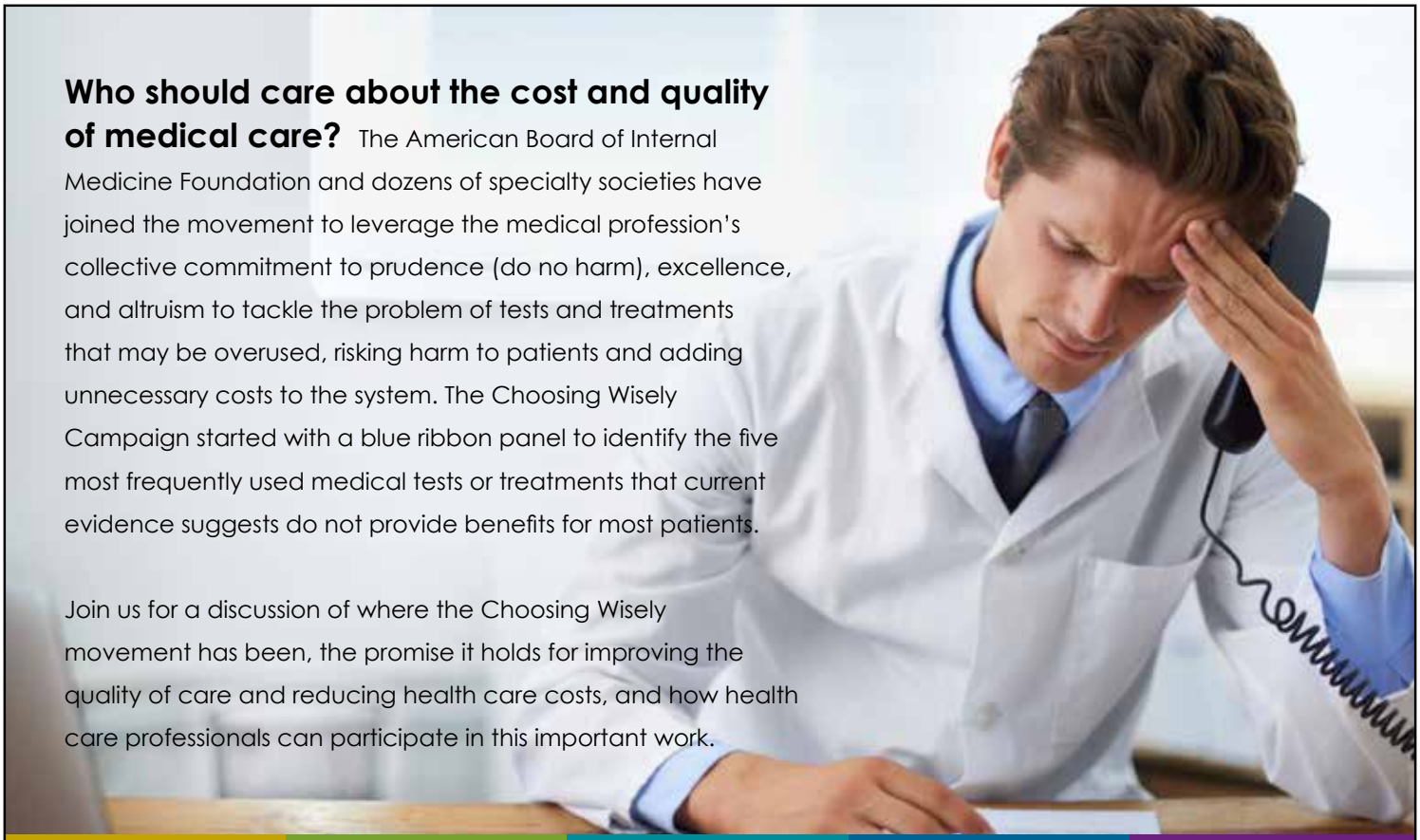
It is felt that the Report will consist of two essential phases: (1) the initial release of material on the Committee's findings, based on a review of scientific data and evaluation—this reporting is expected in the fall of the year; and (2) the recommendation for legislative or Government action, labeling, stricter FTC control, Pure Food and Drug involvement, etc., particularly for state statutes inspired by the Report.

The companies were correct that there was supposed to be a second report on policy recommendations. But the second report was never written, and, aside from weak warning labels being enacted in 1965, together with preemption that shielded the tobacco industry from the state-level action they worried about, the government did not follow up with any of the strong policies they so feared. Indeed, it was not until the grassroots nonsmokers' rights movement took hold around 1980 that per capita cigarette consumption started to drop.

The fiftieth anniversary Surgeon General's Report was released in January. It appropriately celebrates the tremendous accomplishments made since 1964 despite "trench warfare" opposition from the tobacco companies. The real question will be whether now, fifty years later, the Obama Administration will implement the kind of strong public health policies that the tobacco company executives were so afraid of half a century ago. I would start with these:

- Ban menthol in all tobacco products.
- Require large graphic warning labels on tobacco products (and, yes, that could be done even in the current legal environment).
- Prohibit use of e-cigarettes anywhere that smoking conventional cigarettes is prohibited.
- Prohibit advertising of e-cigarettes on television and radio.
- Support Malaysia's proposal to "carve out" tobacco from the Trans-Pacific Partnership Agreement to prevent the tobacco companies from using the TPP to fight tobacco control measures here and around the world.
- Drop the pressure for "fast track" of the TPP so that there can be a full public discussion of these (and other) serious issues that the TPP raises.
- Publicly press media companies to modernize their voluntary ratings system to award an "R" to movies with smoking, to substantially reduce the number of kids who start smoking because of onscreen smoking—on the grounds that the Surgeon General has concluded that smoking in the movies causes youth smoking.

Stanton Glantz, PhD, is professor of medicine and director of the Center for Tobacco Control Research and Education at the University of California, San Francisco.



Who should care about the cost and quality of medical care? The American Board of Internal Medicine Foundation and dozens of specialty societies have joined the movement to leverage the medical profession's collective commitment to prudence (do no harm), excellence, and altruism to tackle the problem of tests and treatments that may be overused, risking harm to patients and adding unnecessary costs to the system. The Choosing Wisely Campaign started with a blue ribbon panel to identify the five most frequently used medical tests or treatments that current evidence suggests do not provide benefits for most patients.

Join us for a discussion of where the Choosing Wisely movement has been, the promise it holds for improving the quality of care and reducing health care costs, and how health care professionals can participate in this important work.

Choosing Wisely:

RATIONING OR COST-CONSCIOUS HEALTH CARE?

Topics and Speakers:

How did it start?: Origins of the Choosing Wisely Campaign
Catherine Reinis Lucey, MD, Vice Dean for Education, University of California, San Francisco and pioneer in the Choosing Wisely Campaign.

What is the relevance to the everyday practice of medicine?
Shannon Udovic-Constant, MD, Immediate Past- President San Francisco Medical Society and pediatrician at San Francisco Kaiser Permanente.

How can other healthcare professionals be involved?
Wanda Borges, PhD, RN, ANP-BC, Associate Dean and Alexa Colgrove Curtis PhD, FNP-BC, FNP Program Director, University of San Francisco School of Nursing and Health Professions

First Do No Harm: The future and potential of cost-conscious care.
Sandra Hernandez, MD, President and CEO of the California HealthCare Foundation and former CEO of the San Francisco Foundation and Director of San Francisco Department of Public Health.

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HEALTH POLICY UPDATE

Steve Heilig, MPH

Choosing (Ever More) Wisely: An Update

Last year, the SFMS delegation to the California Medical Association took this policy resolution to the CMA, where it was adopted—and then adopted by the AMA as well:

REDUCING OVERUTILIZATION: PHYSICIAN LEADERSHIP

Whereas, overutilization of medical services has long been identified as a significant factor in rising health care costs, with costs in the United States significantly higher than in other developed nations at least in part due to significantly higher rates of screening, diagnostic, and treatment procedures, in many cases without demonstrable superior outcomes; and

Whereas, in the new Choosing Wisely initiative sponsored by the American Board of Internal Medicine, nine United States specialty societies representing 374,000 physicians developed lists of "Five Things Physicians and Patients Should Question" in recognition of the importance of physician and patient conversations to improve care and eliminate unnecessary tests and procedures; and

Whereas, these lists represent specific, evidence-based recommendations physicians and patients should discuss to help make wise decisions about the most appropriate care based on their individual situations, and each list provides information on when tests and procedures may be appropriate, as well as the methodology used in its creation; and

Whereas, the American College of Physicians recently published a consensus that named thirty-seven commonly overused diagnostic procedures and treatments, and has called for physicians to become aware of costs of treatment options and to become more "parsimonious" in treatment decisions where evidence indicates costs may not be justified in terms of probable outcomes; and

Whereas, with ever-mounting pressure to control costs, from various health "reforms" and other constraints, it is more important than ever that the medical profession lead the way in ensuring that appropriate guidelines are utilized in utilization and cost containment efforts and policies; now be it

RESOLVED: *That CMA will support physician-led efforts to reduce overutilization of medical services based upon evidence-based criteria; and be it further*

RESOLVED: *That CMA educate member physicians, hospital, and health care leaders and patients about the need for such efforts; and be it further*

RESOLVED: *That this matter be referred to the AMA for national action.*

That said, who might be best to practically address the ever-growing concerns about health costs and efficiency? Physicians would seem to be the best equipped for this tricky task. The Choosing Wisely project addressed in the SFMS resolution starts with that conviction and has been growing since its inception. *San Francisco Medicine* published an entire issue on CW one year ago (Jan/Feb 2013, available at sfms.org); here are some updates from the project site, www.ChoosingWisely.org.

Choosing Wisely aims to promote conversations between physicians and patients by helping patients choose care that is supported by evidence, not duplicative of other tests or procedures already received, free from harm, and truly necessary. In response to this challenge, national organizations representing medical specialists have been asked to "choose wisely" by identifying five tests or procedures commonly used in their field, whose necessity should be questioned and discussed. The resulting lists of "Five Things Physicians and Patients Should Question" spark discussion about the need—or lack thereof—for many frequently ordered tests or treatments. Choosing Wisely recommendations should not be used to establish coverage decisions or exclusions. Rather, they are meant to spur conversation about what is appropriate and necessary treatment. As each patient situation is unique, physicians and patients should use the recommendations as guidelines to determine an appropriate treatment plan together.

New Lists in 2014

More than a dozen leading medical specialty societies will release new lists of specific tests or procedures in 2014 that they say are commonly ordered but not always necessary and could cause harm. To date, sixty societies and sixteen consumer groups have joined the Choosing Wisely effort. The societies continuing to release lists in early 2014 and the dates of their releases include:

January 11: American Association of Critical-Care Nurses, American College of Chest Physicians, American Thoracic Society, Society of Critical Care Medicine (Critical Care)
January 16: Society for Cardiovascular Magnetic Resonance
January 21: American Society of Anesthesiologists* (Pain)
February 3: Society for Maternal-Fetal Medicine
February 10: Heart Rhythm Society
February 24: American College of Occupational and Environmental Medicine
February 27: American Geriatrics Society*
February 28: American Academy of Allergy, Asthma & Immunology*
March 11: American Association of Neurological Surgeons
TBD: American Academy of Physical Medicine and Rehabilitation
TBD: American Association of Blood Banks
TBD: American Association for the Study of Liver Diseases
TBD: American Medical Society for Sports Medicine
TBD: American Society of Colon and Rectal Surgeons
TBD: American Society of Plastic Surgeons
TBD: Society for Cardiovascular Angiography and Interventions

* Releasing a second list

Visit www.ChoosingWisely.org to see lists from more than fifty societies that have already published them.

MEDICAL COMMUNITY NEWS

KAISER

Robert Mithun, MD

For several years providers at the Kaiser Permanente San Francisco Medical Center have been developing and implementing innovative patient care practices through its Dermatology Department. The results of these novel approaches have resulted in increased patient satisfaction and overall improvement of care for those seeking dermatological services. Conceived and launched at the San Francisco Medical Center, our "Roving Dermatologists" provide on-the-spot consultation and care when a patient is seeing his or her primary care provider. If a patient has a question during an appointment, the Roving Dermatologist is a cell phone call away from arriving at the exam room and delivering service. This very popular program saves the patient an additional appointment, co-pay, and trip to the medical center, while also increasing the time that a medical issue can be assessed and treated.

The Roving Dermatologist program allows for a more comprehensive exam and enables the primary care provider to have a greater understanding of a patient's health overall. The innovative service now exists at all Kaiser Permanente medical centers and has improved patient satisfaction exponentially in part due to the overwhelming demand for dermatological services. Another innovation begun in San Francisco is the Teledermatology program, which enables one dedicated dermatologist per day to view photos sent from other Kaiser Permanente locations, where there are fewer dermatologists but a high demand for services, to view and analyze photos taken by a highly trained medical assistant. Providers have expanded the program to include hospital, emergency room, after-hours, and weekend patients where it had formerly been confined to outpatient clinic visitors.

In addition to these programs, patients can now take photos of, for example, a rash or a growth, attach them to a secure email message, and ask a dermatologist for his or her opinion with much faster results than if they had to make an appointment and travel to the medical center.

SFVAMC

Diana Nicoll, MD, PhD, MPA

Dermatology clinics are among the busiest at the San Francisco VA Medical Center (SFVAMC), yet many rural veterans have had difficulty accessing dermatologic care. The need for dermatologic care for veterans is particularly acute because veterans tend to be older, have greater sun exposure, and have greater occupational exposures than the general population.

SFVAMC's Dermatology Service has been committed to increasing access since its inception, dispatching dermatology nurse practitioners to distant clinics for thirty years and instituting one of the nation's first teledermatology programs. These approaches have been highly successful, and with the recent expansion of rural health care for veterans, Dermatology Service has gone a step further. Staff now use teledermatology and didactic rotations through dermatology clinics to train and support primary care practitioners in our rural, community-based outpatient clinics (CBOCs). This service allows primary care practitioners to diagnose and treat many patients who otherwise would have to travel long distances to obtain their skin care. This partnership with our CBOCs also enhances the expertise of the primary care practitioners, who are often able to treat benign or premalignant skin conditions without having to refer patients to SFVAMC.

Training primary care practitioners to perform skin biopsies also allows a biopsy to be done quickly if the provider suspects a skin growth might be skin cancer. If the primary care practitioner is concerned about a patient or unsure of a diagnosis, this allows quick consultation with the dermatologist on call via the teledermatology mechanism. Finally, this system allows appropriate referral for dermatologic surgery with a single visit, avoiding the requirement for patients to travel long distances for a preoperative visit and then make the long trip again for skin surgery. These changes are part of the Dermatology Service's commitment to deliver the best care to our veterans.

SUTTER PACIFIC MEDICAL FOUNDATION

Bill Black, MD, PhD

In the San Francisco Bay Area, our physicians and staff provide personalized care for one of the most diverse populations in the country. Culturally competent care can improve the overall patient experience, help reduce racial and ethnic disparities, and contribute to quality. It also takes every one of us—our physicians and the frontline staff in our care centers—being fully engaged in understanding our patients. From the first encounter, frontline staff and providers greet patients with open-ended inquires to learn more about their backgrounds. That lays the groundwork for a trusting relationship continuing throughout a patient's care.

Charles Moser, MD, an internist specializing in sexual medicine, knows the importance of a patient's background. "Imagine transgendered persons going to a new physician," he says. "First asked for identification, which may not match their presentation—male name and gender, while appearing female, for example. Then, will the medical assistant use Mr. or Ms., or their legal rather than preferred name? Then there are forms offering only male or female as options." To improve the encounter, Dr. Moser provides customized forms, and his staff is sensitive to addressing patients appropriately.

Robert Miller, MD, neurologist and medical director of the Forbes Norris ALS/MDA Research Center, finds using interpreters is key. "Our patient quality of care and compliance with care has risen dramatically. Especially for explaining complex diagnoses, tests, medication, and end-of-life issues, including hospice and advance directives, confident communication with an interpreter is critical." Cultural diversity also attracts providers to this area.

Paul Chin, MD, psychiatry, says that Geisel Medical School at Dartmouth College has sent students for clerkships at California Pacific Medical Center for the excellent training and for the opportunity to care for diverse patients. After a patient interview, one student said, "That was the first non-white, non-African-American patient I've seen." The patient also happened to be transgender, further enriching the experience.

CPMC
Michael Rokeach, MD

Congratulations to Dr. Yuan-Da Fan, chair of the Department of Obstetrics and Gynecology at CPMC, who received the Soong Ching Ling Camphor Award at a ceremony in Beijing this past December. Hosted by the China Welfare Institute, the biannual event pays tribute to individuals who have made outstanding contributions to Chinese women and children's health care, education, and culture. Dr. Fan was honored for his work as professor at Beijing's Haidian Maternal and Child Health Hospital, where he has dedicated his career to passing on his clinical experiences and noninvasive childbirth techniques throughout the country.

The active medical staff members recently elected new medical staff officers and four Medical Executive Committee (MEC) members-at-large. The medical staff officers, Dr. Edward Eisler (chief of staff), Dr. Robert Margolin (vice chief of staff), Dr. Nobl Barazangi (treasurer), and Dr. Oded Herbsman, will serve the first of two eligible two-year terms beginning January 1, 2014, through December 31, 2015.

Dr. Jeffrey Swisher was elected to serve a second and final two-year term as MEC member-at-large, and Drs. Aravind Mani and Nikola Tede were elected to serve the first of two eligible two-year terms as members-at-large. All three will serve from January 1, 2014, through December 31, 2015. Dr. John Rabkin will serve as MEC member-at-large for a one-year term in 2014 due to a vacancy in the position. MEC members-at-large are voting members of the MEC and represent the interests and opinions of the medical staff as a whole as they participate in the resolution of MEC issues and serve on medical staff committees as part of their leadership roles.

CPMC breast cancer researchers presented new findings at the December 2013 San Antonio Breast Cancer Symposium, one of the largest international breast cancer meetings. Drs. Shanaz Dairkee, Gloria Luciani, and William Goodson have found new evidence of potential carcinogenic effects of a chemical found in commonly used plastics and used to make clothes, called terephthalic acid (or TPA).

ST. MARY'S
Robert Weber, MD

It's only February, but 2014 is already a banner year for St. Mary's Medical Center. This month, the hospital received a Distinguished Hospital Award for Clinical Excellence from Healthgrades, which ranks hospital quality and safety nationwide. Only 260 of the country's 4,500 hospitals won this award, including only two in San Francisco. That puts St. Mary's in the top 5 percent for clinical performance across the nation.

This comes on the heels of Becker's Hospital Review naming St. Mary's one of the top 100 hospitals in the country for orthopedic services. These honors crown achievements announced toward the end of 2013, including Healthgrades top-100-hospitals citation to St. Mary's for general surgery, stroke care and gastrointestinal care, and an "A" grade status for hospital safety from the industry watchdog Leapfrog Group.

St. Mary's state of the art equipment and outstanding medical expertise were obviously key factors in helping us win these distinctions. But equally important – if not more so – is the hospital's commitment to excellence. This is not just a vague and airy mission-statement catchphrase. At St. Mary's, excellence begins with the reception patients receive when they walk in the door and continues throughout their stay.

As Healthgrades noted in its citation this month, hospitals that receive its award for clinical excellence have embedded quality into their culture. From our custodians, who keep our patient rooms and medical equipment spotless, to our leadership, which supports compassionate and innovative care, it's clear that excellence is deeply entrenched at St. Mary's. Our staff understands and demonstrates this message with every action, every day. And that's what really makes us proud. The industry recognition is wonderful, of course, but it's just the cherry on top.

SAINT FRANCIS
Robert Harvey, MD

For an ailing patient, imaging can be everything. Technology that would have beggared belief 20 years ago can now unveil the mysteries of the human body and provide personalized roadmaps that hold the key to diagnosis and, ultimately, to healing. At Saint Francis Memorial Hospital, patients stand to benefit from two new systems we recently added to our arsenal of digital imaging technology.

One is Hologic Selenia Dimensions 2D Digital Mammography, a vital tool in our ongoing battle against breast cancer. This system provides high-quality images and computer-aided diagnostic techniques – keys to early detection.

Our other new system is the Toshiba Aquilion Prime Volumetric CT, which will enable us to perform ultra-fast, low-dose, 3-D vascular and skeletal examinations. Cardiac patients in particular will benefit from this effective, less invasive technique for diagnosing coronary artery disease. Saint Francis Memorial Hospital is proud to be the only facility in Northern California to offer this cutting edge technology.

In addition to producing superb image quality, both these new systems both provide a more comfortable experience for patients. And for physicians, the systems allow for safer and more accurate guidance during invasive surgical procedures.

These two new imaging machines were on display when the Saint Francis Radiology Department hosted an open house on January 28th. The event was attended by numerous physicians and staff, many of whom expressed amazement at the imaging capabilities now in place at Saint Francis. The entire Saint Francis staff owes sincere gratitude to the Saint Francis Foundation, whose generous gift made it possible to purchase the new equipment.

Of course, no matter how advanced our machines, they're only as good as the technicians who run them and the physicians who interpret and implement their findings. We're happy that we can confidently offer Saint Francis patients the whole nine yards.

SFDPH Influenza Advisory

JANUARY 8, 2014: The San Francisco Department of Public Health (SFDPH) provides this guidance based on current information. SF recommendations may differ from those issued by the Centers for Disease Control and Prevention (CDC) and the California Department of Public Health (CDPH). For updates, forms, and FAQs visit sfcdcp.org/flu.

SITUATIONAL UPDATE

Although it is early in the influenza season, influenza activity is expected to increase substantially in the coming weeks to months. The predominant influenza virus this season to date is influenza A(pH1N1). This is the same virus that caused the 2009 pandemic. Some hospitals are reporting cases of non-elderly adults with critical illness due to pH1N1 virus, similar to the epidemiology observed during the 2009 pandemic. To date one death due to pH1N1 has occurred in San Francisco, in a non-elderly adult with an underlying medical condition. Vaccination and good infection control practices remain the best prevention strategies for seasonal influenza. This advisory is an update to our Influenza Advisory dated 11/7/13. For detailed information concerning seasonal influenza, please refer to the 11/7/13 document. sfcdcp.org/healthalerts.html

ACTIONS REQUESTED OF ALL CLINICIANS

1. Vaccination: All persons aged 6 months and older, including health care personnel, should receive influenza vaccination now. The pH1N1 strain is included in this year's influenza vaccine formulations.

2. Empiric antiviral treatment: Start treatment with oral/enteric oseltamivir for suspected influenza as soon as possible for the following groups:

- Hospitalized patients
- Outpatients with severe/progressive illness
- Patients at high risk for influenza complications, including persons age <2 years or ≥65 years; persons with chronic pulmonary, cardiovascular, renal, hepatic, hematological, neurologic (including neurodevelopmental), and metabolic disorders; persons with immunosuppression, including from medications or by HIV infection; women who are pregnant or postpartum (within 2 weeks after delivery); persons aged <19 years who are receiving long-term aspirin therapy; American Indians/Alaska Natives; persons who are morbidly obese (i.e., BMI ≥40); residents of nursing homes and other chronic-care facilities.

Healthy, non-high-risk persons can also experience severe and fatal complications associated with influenza, especially with pH1N1 virus infection, so antiviral treatment is reasonable in healthy, symptomatic outpatients. For detailed guidance concerning antiviral treatment in critically ill patients, including issues of antiviral resistance and the use of investigational medications, see cdph.ca.gov/programs/dcdc/Documents/CDPHUpdateSevereInfluenzaH1N1.pdf.

3. Testing: For influenza testing in severely ill patients hospitalized more than 24 hours, RT-PCR is recommended.

- Specimens collected on critically ill or fatal cases with suspected or laboratory-confirmed influenza may be referred to the SFDPH Laboratory for further PCR confirmation and subtyping.
- SFDPH may request retained specimens from fatal cases, which will be forwarded to CDPH for viral culture, strain typing, and antiviral resistance testing in order to characterize the circulating strains, guide antiviral treatment recommendations, and look for the emergence of novel strains.
- Oseltamivir resistance, sometimes within 1 week of treatment initiation, has been reported, particularly among immunocompromised patients with pH1N1 virus infection who were receiving treatment with oseltamivir. SFDPH can coordinate testing of these specimens for antiviral resistance in certain circumstances.
- ALL requests for flu testing by SFDPH laboratory must be coordinated through and approved by SFDPH Disease Control (415) 554-2830. Instructions and forms can be found at sfcdcp.org/influenzareporting.

4. Reporting: Fatal cases of lab-confirmed influenza in persons 0-64 years, whether hospitalized or not, are reportable by California law. As soon as possible (but no later than 7 days after the death), complete a case report form (see sfcdcp.org/influenazareporting) and fax to SFDPH at (415) 554-2848, or call (415) 554-2830 to speak with a disease investigator.

5. Infection control: Cases of critically ill patients with health care-associated influenza have already been reported in the U.S. this season.

- Vaccination of health care personnel is essential, and vaccination or masking is mandated for workers in hospitals, skilled nursing, and other long-term care facilities in San Francisco. See sfcdcp.org/fluproviders.html for more information concerning the San Francisco vaccination mandate. Health care personnel should also be instructed not to come to work when ill.
- Standard and droplet precautions should be implemented for confirmed and suspected influenza patients. Influenza patients should be isolated in a single room or cohorted with other influenza patients if a single room is not available.
- For detailed information concerning infection control practices for influenza, see cdc.gov/flu/professionals/infectioncontrol/index.htm.

SOLICITATION FOR SENTINEL PROVIDERS FOR INFLUENZA SURVEILLANCE

Primary care providers are invited to enroll as sentinel providers for influenza surveillance in San Francisco. Compiling and reporting data usually takes less than 30 minutes per week. If interested in participating, contact the CDPH Immunization Branch at influenzasurveillance@cdph.ca.gov or (510) 620-3737.

REMINDERS

- SFDPH website influenza page: sfcdcp.org/flu
- SFDPH website health alerts: sfcdcp.org/healthalerts.html
- CDPH website influenza page: cdph.ca.gov/healthinfo/discond/pages/influenza(flu).aspx
- To report influenza deaths and/or cases or outbreaks as described above, call (415) 554-2830.
- Within San Francisco, the public can call 311 for basic information about influenza.

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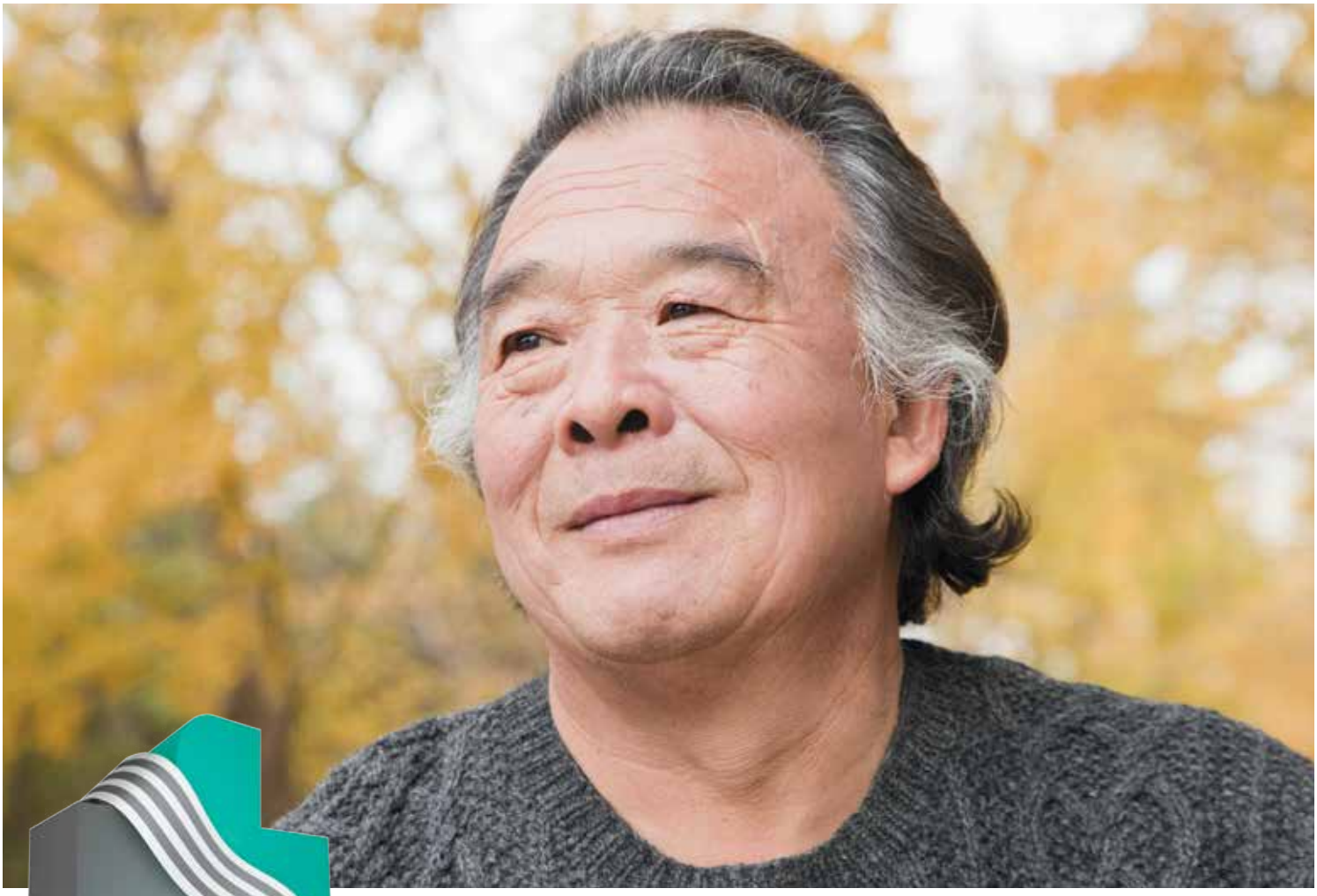

CULTURALLY-SENSITIVE CARE WITH LEADING EXPERTS IN LOCAL COMMUNITIES.

Sutter Health's California Pacific Medical Center Department of Transplantation provides unparalleled care for a diverse community. CPMC's San Francisco Center for Liver Disease and Department of Transplantation was the only center in California to recently receive the Department of Health and Human Services Silver Award for superior liver transplantation outcomes, which were in the top 4% in the nation. Eleven regional clinic offices throughout Northern California including the Central Valley and Nevada provide exceptional, convenient and unrivalled access to our physicians and staff. It's one more way we plus you.

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