Medical Directors Newsletter
December 2020

“This dramatic escalation of global travel highlighted the perils of emerging infectious diseases.”

--Dr. Wu Lien-teh, talking about the role of railroads on the spread of the Manchurian pneumonic plague of 1910

The Origin of the N95 Mask

Born in Malaysia and trained at Cambridge, London, and Paris, Dr. Wu Lien-teh was sent by the Chinese government to control an outbreak of almost universally-fatal pneumonic plague in Manchuria in 1910. He determined that this form of plague was transmitted from person to person by respiratory droplets and developed cloth masks to protect health care workers. European infectious disease physicians initially did not believe Dr. Lien-teh’s findings, partly due to bias against him for being ethnic Chinese. French physician Dr. Gerard Mesny and Scottish physician Arthur Jackson both refused to wear a mask in the hospital treating patients with pneumonic plague, to demonstrate their disagreement with Dr. Lien-teh’s hypotheses. Both contracted pneumonic plague and died.

Refusal to wear masks as a statement of what the person believes, with deadly consequences, is not new to COVID-19. Sadly it has a long history. Luckily, the masks initially used in Manchuria were adapted over the years into the N95 mask and associated personal protective equipment (PPE) we use today.

Dr. Wu Lien-Teh eventually traced the source of the pneumonic plague to trappers of the Mongolian Marmot, which was endemic carrier of plague. He used a number of measures to study and control the outbreak, including mass cremation of individuals who died, which were unpopular among local officials and the local population. He had to appeal directly to the Chinese emperor for support. Like COVID-19 today, the support of the most senior leader ultimately determined if public health measures would be embraced or not, against resistance of the population.

After COVID-19 is under control, we need to think about how we train not only public health experts, but also non-scientists who may be future political leaders, about the leadership lessons and ethical tradeoffs of past epidemics to try to prevent repeating deadly mistakes of the past in the next pandemic.

Breaking News

Using Monoclonal Antibodies for Early COVID in Higher Risk Patients

With hospital capacity strained, we must do what we can to lessen the risk of COVID-19 that requires hospitalization.

Two different monoclonal antibody products against the SARS-CoV2 spike protein were granted emergency use authorization by the FDA in November. With all the excitement about vaccines being close to being approved, this other advance is not gaining the recognition it deserves.

Trial data submitted to the FDA showed that a single infusion administered early in the course of disease (in those not requiring oxygen or hospitalization) reduced the risk of hospitalization from about 10% to about 3%. Both are approved for adults and also for children down to age 12, if they meet certain risk criteria.

The first product is bamlanivimab (produced by Eli Lily), and the second is a combination of casirivimab and imdevimab (produced by Regeneron; the experimental treatment used on President Trump). Both are currently available through **county health departments**, free of charge; the cost of the infusion center is paid by PHC for our members. Since all patients treated are actively infectious with COVID-19 at the time of treatment, strict infection transmission precautions are essential. Currently we are only aware of hospitals agreeing to provide this infusion at either their emergency room or in an infusion center.

While most patients tolerate the infusion well, there have been reported cases of allergic reactions, mostly rashes, but occasionally including anaphylaxis, so epinephrine, emergency response equipment and trained staff must be present for infusions. Patients are generally pre-treated with diphenhydramine (Benedryl) and acetaminophen, similar to pre-treatment for blood transfusion to prevent or reduce the severity of milder reactions.

Eligible patients must have **all of the following**:

1. Has a positive direct SARS-CoV-2 test, PLUS
2. Is not sick enough to require hospitalization, PLUS
3. Is not sick enough to require oxygen therapy, PLUS
4. Is at high risk for progressing to severe COVID-19 and/or hospitalization, PLUS
5. Is within 10 days of symptom onset

The EUA explicitly states that these monoclonal antibodies are *not authorized for use* in patients:

1. Who are hospitalized due to COVID-19, or
2. Who require oxygen therapy due to COVID-19, or
3. Who require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity

The list of risk categories that may use the drug is long and includes a large percentage of those with COVID. If supply is short at first, those with *multiple risk*

factors should be the highest priority. Here are the approved risks, any one of which technically qualifies for eligibility for treatment:

- Have a body mass index (BMI) ≥35
- Have chronic kidney disease
- Have diabetes
- Have immunosuppressive disease
- Are currently receiving immunosuppressive treatment
- Are ≥65 years of age
- Are ≥55 years of age AND have
  - cardiovascular disease, or
  - hypertension, or
  - chronic obstructive pulmonary disease/other chronic respiratory disease.
- Are 12 – 17 years of age AND have
  - BMI ≥85th percentile for their age and gender based on CDC growth charts, or
  - sickle cell disease, or
  - congenital or acquired heart disease, or
  - neurodevelopmental disorders, for example, cerebral palsy, or
  - a medical-related technological dependence, for example, tracheostomy, gastrostomy, or
  - positive pressure ventilation (not related to COVID-19), or
  - asthma, reactive airway or other chronic respiratory disease that requires daily medication for control

If you have a patient with early COVID-19 that you think would be a good candidate for one of these monoclonal antibody treatment to reduce the risk of hospitalization (especially important with the current strain on the health care system), please contact your local county health department and local hospital to coordinate.

For more information on the monoclonal antibody treatments, see the December 3 Medicare instructions, or this summary article.

Options for Screening Infants for Elevated Lead Levels

In prior newsletters, we have reviewed the new enforcement of the DHCS/CMS requirement that all children be screened for elevated lead levels at age 12 and 24 months.

We know of four different options for PCPs to conduct these screenings, each with their own pros and cons:

1. Venous blood draw, conducted at a commercial laboratory, like Quest or Lab Corps. This is the gold standard for accuracy, without the false positives sometimes found with the remaining three options. However, a venous blood draw for infants can be challenging if the phlebotomist is not experienced in pediatric blood draws, resulting in a bad experience by the infant and their parent. In addition, many parents who receive the order for the lead screening fail to follow up by going to the lab for the blood draw.
2. Point of care capillary blood screening for lead, done in the PCP office. The capillary collection is similar to collecting a specimen to test for anemia (hemoglobin), but requires a different skin prep to decrease the chance of

contamination by lead on the skin. Elevated levels (above 5 micrograms/dl) require a secondary confirmatory test with a venous specimen. The device used by offices that is FDA approved is called the Leadcare II, which costs about $2400 for the device and the testing materials cost about $8 per test. Office lead testing requires more oversight than other CLIA waived tests, including a requirement that all results be submitted to the California Department of Public Health and a separate parallel certification and quality control process.

3. Collection of a capillary specimen in the PCP office, which is then transported to a local public health laboratory or commercial lab for analysis. This offers the advantages of point of care testing (higher adherence to testing, less traumatic specimen collection), without the office bearing the cost, staff time or regulatory requirements associated with point of care lead testing. Specimens are stable for 48 hours at room temperature or 7 days if refrigerated. Like the point of care testing, results showing elevated levels need to be confirmed with a venous specimen. This model is used in Solano, Humboldt and Del Norte Counties. It takes some coordination with the reference lab to set up.
4. New: LabCorp is introducing a filter paper test similar to newborn screening tests. These are stable for up to 30 days. Quest does not yet offer this option. Special training of staff may be needed, since this is different from the capillary specimens used for in-office hemoglobin tests.

On a side note, a study published in the November 17, 2020 JAMA evaluated the long term neurocognitive and CNS structural effects of elevated lead levels in a population in New Zealand in which the lead exposure pattern was *not* associated with sociocultural factors (unusual in studies of infant lead exposure). Prior study of this population showed a linear decrease in long term IQ in relation to blood lead levels when the study subjects were children. In this study, several measures of impaired brain architecture were similarly associated with increased childhood lead levels. This adds a plausible biological mechanism to the associated cognitive deficits noted in prior studies.

Optimizing Office Staff Practices to Support Video Visits

Primary care clinicians who are willing and able to use video technology to deliver care will be more successful if the office builds the necessary and critical physical and personnel infrastructure. Managers of primary care practices that have increased the amount of care delivered over video have focused their energies on operational workflows and training of office staff to help build this capacity.

Partnership HealthPlan of California (PHC) is sponsoring an educational webinar targeted to support all staff members in order to help make video visits a success. ResolutionCare, a palliative care provider serving many rural PHC counties, has built its business on optimizing video visits to connect meaningfully with patients dealing with life-limiting illness. Clinical Director Marie Guthrie and Operational team member Leanne Lynch, will remind us of why video care is superior to phone care, and share best practices gleaned from many years of experience in providing quality care over video.

Target audience: Front office staff (receptionists and telephone service staff), back office staff (medical assistants and nurses), office managers, and clinical leaders interfacing with operations.

Title: Care Through Video: Key Skills for PCP Office Staff.

Date: Wednesday, December 16, 2020
Time: Noon to 1 p.m.
Cost: Free for PHC Provider Offices
Sign-up Now

We hope this webinar will assist your practices and health centers with making the changes needed to successfully adopt video primary care visits on a larger scale. As the Institute for Healthcare Improvement states: “Not all change results in improvement, but all improvement requires change.”

New ACEs Aware Grant Opportunity to Support Trauma-Informed Networks of Care

Submission Deadline: December 21, 2020

The Department of Health Care Services in partnership with Office of the California Surgeon General and the California Department of Public Health today released a Request for Proposal (RFP) for a second round of ACEs Aware grants, with a submission deadline of December 21, 2020. The new grants will target California communities that want to build or execute a robust Network fo Care to effectively respond to ACEs and toxic stress to meet the needs of children, adults, and families.

Two types of grants will be available – network of care planning and network of care implementation. Planning grants are targeted for communities that have a high prevalence of ACEs, rural areas, tribal communities, or other communities that do not have existing ACEs response activities underway. Implementation grants will be awarded to communities that demonstrate a high level of readiness and engagement with Medi-Cal providers to operate trauma-informed networks of care.

For more information, please visit the ACEs Aware website: ACEs Aware Grants.

Virtual Diabetes Specialty Clinic (VDiSC) Study

The Jaeb Center for Health Research (a freestanding, nonprofit coordinating center for multi-center clinical trials and epidemiologic research) is conducting a one-year virtual study to see if a virtual diabetes clinic model can help adults who live with diabetes improve their diabetes management. Participants will work with a virtual clinic team who will teach them how to start and use a continuous glucose monitor (CGM) without a visit to the doctor’s office. The virtual clinic team is made up of healthcare professionals like Certified Diabetes Care and Education Specialists, endocrinologists and behavioral coaches. This team will work to make changes that will help patients take care of their diabetes and provide support for stress related to diabetes management.

Ideal candidates will have type 1 diabetes or difficult to conrol type 2 diabetes AND not already be effectively using continuous glucose monitoring.

For more information on who can participate, what the study involves and next steps, please visit the VDiSC webpage. You can also contact the VDiSC Study Team via email: VDiSC@jaeb.org, or phone: (813) 975-8690. The VDiSC Study Team's hours of operation are Monday-Friday, 8 a.m. – 5 p.m. Eastern Standard Time.

Simplifying Specialty Referrals for Primary Care Providers

PHC now offers direct specialty care telehealth services for many specialties. The patient does not need to come to a PCP office with a telemedicine unit; they can access the specialist directly from their home.

Direct specialty telehealth referrals are available for these specialties:

- Dermatology
- Endocrinology
- Infectious Disease
- Rheumatology
- Pulmonology
- Pediatric Dermatology also available for 17 and under

Direct specialty telehealth services are being provided by "TeleMed2U" for a select set of specialties but we will continue to expand these services to providers as the need for additional specialty care services arise.

Any PHC primary or secondary member 18 years and older (except as noted for pediatric services) are eligible to receive care from TeleMed2U specialists and can be referred to TeleMed2U directly.

It's easy to refer, here's how:

1. Login to PHC's provider directory
2. Conduct a search for "Telehealth", "TeleMed2U" or the "Specialty" needed
3. Locate TeleMed2U's contact and referral information
4. Send the referral and the patient's medical records securely by email or fax directly to TeleMed2U
5. TeleMed2U will coordinate patient scheduling
6. TeleMed2U will also send the clinical notes from the telehealth visit back to you

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

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

Interested providers will need to complete the DME Request Form on our website. Complete the form and submit to request@partnershiphp.org or fax to 707-420-7855.

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

PHC Educational Opportunities and Events

Quality & Performance Improvement Training Events

For up-to-date events and trainings by the Quality and Performance Improvement Department, please view our Quality Events Webpage.

Recommended Educational Opportunities Outside of PHC

CSAM State of the Art Addiction Medicine Available Online

Earn up to 17.25 AMA PRA Category 1 Credits™ and 16.25 MOC credits!

The California Society of Addiction Medicine (CSAM) brings together national experts to share frontiers of research, treatments, and policies in the field of Addiction Medicine. This conference covers expansion of treatment into correctional health, hospital consultation services, emergency rooms, and even across the Border. It will cover how, despite the pandemic, telehealth can reach those who are isolated. It will address the worrisome trends in fentanyl, methamphetamine, tobacco and benzodiazepines use; legalization of cannabis, treatment updates for youth, cannabis and alcohol in pregnant women; and novel treatments such as non-benzodiazepines for alcohol withdrawal and psychedelics for substance use disorders.

The activity consists of 22 lectures that were presented live (virtually) on September 22-25, 2020.

Member Rate: $345
Non-Member Rate: $495
More Information
Registration

Addiction Treatment Starts Here: Primary Care

For the last five years, Center for Care Innovations (CCI) has designed and lead two programs focused on improving treatment for people with opioid use disorder. Combined, these programs supported more than 70 primary care health centers in California with designing new or expanding existing Medications for Addiction Treatment (MAT) programs. MAT includes FDA-approved medications for opioid use disorder: methadone, buprenorphine, and naltrexone.

Learning Collaborative

Description: Learning intensive, a mix of expert and peer-led content focused on helping health center teams design and implement new MAT programs into primary care: includes quality improvement methods to optimize planning and testing changes. Each site selected will be eligible for a grant of up to $45,000.

Eligibility & Funding:

- Primary care health center sites that are new to MAT

- Have 5 or fewer patients who regularly receive MAT for opioid use disorder
- Do not have formalized policies and procedures in place for the provision of MAT

Informational Webinar
Date: December 09, 2020
Time: 10 a.m. – 11 a.m.
Sign-up Now
Application Due: January 08, 2021

Learning Network

Description: Peer-led forum for health center sites with mature MAT programs; focuses on promising practices and expertise to strengthen programs and expand to other sites and populations.

Eligibility & Funding: Alumni of Treating Addiction in the Primary Care Safety Net and Addiction Treatment Starts Here are eligible to participate.In lieu of grants to participants, CCI is offering a free peer-led environment that will offer an array of technical assistance and support to strengthen and expand existing MAT programs.

Informational Webinar
Date: December 16, 2020
Time: 10 a.m. – 11 a.m.
Sign-up Now
Application Due: February 15, 2021

Bridging the Gap in Children's Health in the Post-COVID 19 California

Every Smile Counts! invites medical and dental providers to join for a presentation and facilitated discussions on *Bridging the Gap in Children's Health in a Post-COVID 19 California.* Low utilization of children's preventive and dental care challenged the Medi-Cal program before the COVID 19 public health emergency, but the pandemic has resulted in a steep decline in children's visits. In September, the Centers for Medicare and Medicaid Services released data showing a drastic decline in care for children compared to prior years. Missed services put the health of millions of children at risk both in the short and long term and exacerbate disparities. It is critically important for providers to work together to connect children to care. During this convening, attendees will hear updates on trends in children's health care and efforts related to increasing children's utilization of services during the public health emergency. Attendees will also engage in facilitated peer discussions to share experiences, needs, solutions, and best practices to close the gap in children's health and dental care. *This meeting is ONLY for medical and dental providers and space is limited.*

Learning Objectives - At the end of this webinar, you will be able to:

- Describe the latest trends on the impact of COVID 19 on children's health care utilization.
- Describe how medical and dental providers in California are adapting care delivery in response to the COVID 19 pandemic.
- Identify additional ways to integrate care with medical and dental practices and other providers.

- Identify lessons learned from other providers to increase children's utilization of services.
- Recognize upcoming policy advocacy opportunities to influence children's care.

Date: December 10, 2020
Time: Noon – 1 p.m.
Sign-up Now

Applied Motivational Interviewing Workshop

Motivational Interviewing (MI) has a strong evidence base for working with people who are ambivalent about behavioral change. However, many practitioners have received only basic training in MI. This workshop will offer the opportunity to apply more advanced approaches when using motivational interviewing, as well as an opportunity for participants to discuss the application of MI to their own, real-life clinical scenarios.

This training is especially recommended for **teams** of clinicians, case managers, and other professionals as it helps to assure that the team is functioning from a shared framework and vocabulary when it comes to helping people address ambivalence.

***Please Note:** This is not an introductory training. Participants should be familiar with motivational interviewing and have some experience using MI in their practice.

Dates: January 12 & 20, 2020
Time: 9 a.m. – 1 p.m.
Training Fees: $300 per attendee
Sign-up Now

Criminal Justice and Public Health

Free Online/Virtual Seminar

Description: This course will provide an overview of the intersection between the criminal justice system and public health. Students and community participants will gain an understanding of mass incarceration as a social determinant of health and a major public health challenge in the U.S.

Topics include: the history and philosophy of incarceration, institutionalized racism, criminal justice policy, police violence, the collateral consequences of incarceration, health issues in prisons and prison health care system, impacts of incarceration on women, families and communities, the school to prison nexus, juvenile justice and prevention, disability justice, reentry and post-incarceration health, wrongful conviction and exoneration, and restorative and transformative justice.

Date: Tuesdays, January 12, 2021 – April 20, 2021
Time: 4:30 p.m. – 7:30 p.m.
Sign-up Now

QualityImprovement**+**

Update: Courses have been moved from November 2020 to January 2021. There is still time to sign up!

Description: "QualityImprovement+ (QI+) is a nine-month online program that supports the unique training and staff development needs of community health centers (CHCs) to build the fundamental skills and infrastructure necessary to adapt

and position themselves for current and future value-based care delivery. QI+ participants will engage participants in virtual group learning, group webinars, self-directed learning, applied project-based learning, and group technical assistance calls to support project-based learning."

Targeted Audience: "Community health center staff who are responsible for leading quality improvement efforts within their organization."

Dates: January 14, 2021 – August 12, 2021
Cost: Members, $2,500/person; Non-Members: $3,500/person
Sign-up Now