

## **Medical Directors Newsletter March, 2022**

**“People almost invariably arrive at their beliefs not on the basis of proof but on the basis of what they find attractive.”**

**–Blaise Pascal**

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### **Use and Misuse of “Evidence Based”**

Clinicians strive to base our diagnostic and treatment practices on appropriate interpretation of scientific studies. The Evidence Based Medicine (EBM) movement has grown in the past 50 years to help create frameworks for evaluation and application of such studies. The worthy goals of EBM are to avoid unnecessary interventions that can potentially harm patients, and improving the health care that we do provide.

The term “evidence based” is sometimes misused.

I recall a resident physician from UCSF, commenting on a particular intervention: “there is no good evidence that this intervention works.” In this case, however, there was no strong evidence for *any other intervention*, including the one used at UCSF. The resident earlier had pointed to previous studies that showed both a lack of statistical improvement with an intervention, and a “trend towards benefit.”

On the other hand, a study *can* be done that shows that an intervention has no benefit. These two situations are not equivalent. “Lack of evidence of benefit” is not the same as “evidence that an intervention does not work.”

In the first case, a clinician can very defensibly try out the intervention if there is not established superior treatment. In the second case, when studies definitively show no benefit, a clinician would arguably be practicing substandard medicine to use the particular intervention.

Evidence based medicine was also misused several times in the Covid-19 pandemic. Transmission of earlier Coronaviruses causing SARS-1 and MERS was found to be impeded by use of masks. Early in the Covid-19 pandemic, before studies could have been conducted proving that use of masks also reduced transmission, the Center for Disease Control and Prevention (CDC) stated that mask wearing by the public was not recommended, because of the absence of evidence that masks helped. It incorrectly implied that absence of evidence of benefit meant that there was no benefit, even though the prior probability based on related viruses suggested that a benefit was likely. When the evidence became available and the message flipped to recommend masks and later highly effective masks to prevent transmission, this fundamental change in recommendation contributed to lack of trust in the CDC.

In behavioral health and social science research, the “evidence-based practice” is a standard requirement for programs to be funded. For example, an academic study of a new behavioral counseling technique might show that it reduces depression symptoms by 5%, from an average PHQ9 score of 20 to 19. Technically, this is evidence based—a published study showing a benefit of this intervention. Many government grants would allow this intervention to be implemented more widely.

Implementing this “evidence-based” intervention would be a mistake, for two reasons:

First, the setting that this academic study was done almost certainly differs from any real-world setting. “Implementation science” studies such questions. In general, four different replications of a behavioral intervention in different settings all with a similar benefit are needed to have a 95% or greater confidence that another implementation of this intervention will also have the same benefit.

Second, although the 5% reduction may be statistically significant, is it not *clinically meaningful*. Sadly, one often has to read scientific studies carefully to see if a difference is clinically meaningful.

The term “evidence based” has also been used to disparage a person’s educational level. For example, a community health worker (CHW) with at 10<sup>th</sup> grade education may be intuitively skilled at connecting with clients and getting them to change behavior yet lose a job to a more educated and articulate applicant if the hiring manager, instead of recognizing that the CHW has not been trained on “evidence-based approaches,” says that the CHW does not *use* such approaches. This statement is arguably a reflection of implicit bias against someone with less formal education.

All of these examples of misuse of “evidence based” are a reflection of cognitive biases of one form or another. In the first case, the resident preferred one approach over another and incorrectly used the term “evidence based” to disparage one approach and prop up another. This is sometimes called the “confirmation bias” or the “my side” bias, a very common and very human bias to which scientists are not immune. In the second case, many Asian countries commented on the bias against public mask wearing in the United States, which likely played a role in the early recommendation to NOT wear masks to limit the spread of Covid-19. In the third case, the confirmation bias is also at play, because the researcher really wants something important to come out of their research, as this more often leads to publication of studies, invitations to give talks, and academic reputation.

When someone smart uses “evidence based” to promote or disparage a particular practice or treatment, our internal bias-detection should move into high gear. Switch to system 2 thinking ([slow thinking](#)), and critically review the underlying evidence for statistical significance, clinical meaningfulness, and replicability.

## Breaking News

### Update on Covid Flexibilities

During the Covid pandemic, Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS) and Partnership HealthPlan of California (PHC) have instituted a number of flexibilities in previous rules and standards of care, to balance the dangers of Covid with the need to provide health care as safely and responsibly as we can.

Phone visits and video visits are permitted in lieu of office visits or home visits through the end of 2022.

Of note, now that Covid levels have dropped, we expect that pediatric preventive visits will be done in person, in whole or in part. This is the standard promulgated by American Academy of Pediatrics (AAP) and DHCS. The public health rationale for balancing the risk of in-person visits during Covid will no longer be considered a justification for performing pediatric preventive visits entirely virtually. Note that the well child visit HEDIS measure is now an administrative measure, so billing codes for preventive visits do count toward HEDIS and QIP measure, regardless of the modifier.

PHC is focusing our medical record audits on visits completed by telemedicine, including preventive health visits. While most of these visits were conducted appropriately, we have encountered a number of examples where the clinical circumstances clearly indicated an examination was needed.

One common example is the ordering of advanced imaging requests after a virtual visit, without performing a physical exam, first. A second example is patients without Covid symptoms but with some sort of potential exposure who were excluded from coming in for an appointment, regardless of the complaint. (Remember the parking lot visit?) A third example is an appointment for a complaint that clearly could never be done virtually but was scheduled that way nonetheless, because the criteria given the schedulers was insufficient.

Please review the process you use to decide which visits are okay to be virtual and which ones are not. Ensuring that virtual visits are appropriate is important if we want regulators to continue to allow telephonic virtual visits.

### Surplus of Covid-19 Therapeutics Available

During the Omicron wave of Covid, the small amount of Paxlovid and lack of effectiveness of many monoclonal antibodies led to a sense of scarcity: that these options for early treatment of Covid should be reserved for those most likely to become ill, perhaps elderly patients who were unvaccinated. In fact, the CDC still has information on prioritization of treatments on [its website](#).

As Omicron has subsided, the available supply of Paxlovid, sotrovimab, remdesivir, and bebtelovimab, all effective in preventing severe disease in those with Omicron,

has grown faster than the demand for its use. Many counties are turning away offers of more sotrovimab and bebtelovimab, as they had run out of room to store doses.

As a result, public health officials are working to reframe physician thinking about these treatments, from scarce resources to be rationed, to a resource to be used for a wider group of patients at risk. Criteria for use has now returned to the original risk categories, including not just chronic heart and lung disease, but also obesity, those with chronic mental health issues, and anyone over the age of 65, regardless of vaccination status. The CDC has a full list of conditions on [its website](#).

We recommend consulting with your local health department and larger health centers on the locations with these treatments in stock. The standard of care is now shifting to much more widespread treatment. Spread the word to your providers, and set up systems to screen those who call into the office for potential treatment, in addition to the usual recommendation to isolate at home.

The CDC recommends prioritization of treatments in this order (most preferred to least preferred), for those with early Covid and a risk factor:

1. Paxlovid
2. Soltrovimab
3. Remdesivir
4. Bebtelovimab
5. Molnupiravir

A proposal by the federal government to make these treatments available in pharmacies without physician prescription (test and treat) is stalled, as clinician groups point out the complex drug-drug interactions and other reasons they believe a clinician who can access the patient's medical history should be involved in the decision to treat.

## Testing for Streptococcal Pharyngitis is Low in PHC Members

The standard of care for treatment of streptococcal pharyngitis is to confirm infection with a rapid strep test or throat culture prior to prescribing antibiotics, or at the latest concurrent with antibiotic treatment.

As summarized in [UpToDate](#):

Empiric treatment is generally not recommended, as the clinical features of GAS pharyngitis and non-streptococcal pharyngitis broadly overlap. Short delays in therapy (e.g., while awaiting culture results) have not been associated with increased rates of complications such as acute rheumatic fever. However, whether such delays effect rates of other complications (e.g., development of peritonsillar abscess) is not known. If clinical suspicion for GAS pharyngitis is high and testing results cannot be obtained rapidly, it is reasonable to start antibiotic treatment while test results are pending. If testing does not confirm the diagnosis, antibiotics should be discontinued.

According to the [Cochrane Library summary](#):

Sore throat is a common condition caused by viruses or bacteria, and is a leading cause of antibiotic prescription in primary care. The most common bacterial species is group A streptococcus ('strep throat'). Between 50% to 70% of pharyngitis cases are treated with antibiotics, despite the majority of cases being viral in origin. One strategy to reduce antibiotics is to use rapid tests for group A streptococcus to guide antibiotic prescriptions. Rapid tests can be used alone or in combination with a clinical scoring system. Rapid testing to guide antibiotic treatment for sore throat in primary care probably reduces antibiotic prescription rates by 25% (absolute risk difference).

NCQA has a HEDIS measure that looks at the lack of any strep test associated with antibiotic prescription for strep pharyngitis, called "Appropriate Testing for Pharyngitis" or CWP. Nationally, the 50<sup>th</sup> percentile for this measure is 77% percent in Medicaid—this means 77 of 100 individuals age three and over with a diagnosis of strep pharyngitis had a test done associate with this diagnosis.

The rate of testing is far lower for PHC members. The overall rate is just 55% which is far below the 25<sup>th</sup> percentile. The rate did drop about 20% during the Covid pandemic, likely a product of the increased use of virtual visits, and hesitation to send patients to the office or a lab for confirmatory testing. As Covid wanes, it is important to move back to the standard of care for this illness, and perform confirmatory testing, before or concurrent with treatment.

So you can estimate how much behavior change in your clinicians is needed, here is the data for 2021, by PCP:

PCP site	Numerator Compliant %	PCP site	Numerator Compliant %
ADVENTIST HLTH, UKIAH VALLEY (22860)	94.4%	ALLIANCE, MED CT WINDSOR (19393)	60.0%
FALL RIVER, VALLEY HC (22704)	93.3%	SRCH PEDIATRIC, CAMPUS (15634)	58.8%
LASSEN, MEDICAL CLINIC (39299)	92.9%	HILL COUNTRY, COMM CLINIC (27936)	57.9%
SUTTER COAST, COMMUNITY CLIN (20771)	91.3%	ADVENTIST HLTH, CLEARLAKE (26801)	56.3%
WOODLAND, CLINIC (40299)	88.0%	SOLANO COUNTY, HLTH SVC (1013)	55.6%
NORTHCOUNTRY, CLINIC (28025)	87.5%	DEL NORTE COMM, HEALTH CENTER (2266)	55.3%
NORTHEASTERN, RURAL HLTH CLI (7477)	86.0%	CONSOLIDATED, TRIBAL HEALTH (10111)	55.2%
MCKINLEYVILLE, COMM HLTH CTR (13183)	83.9%	CENTER, OF HOPE (35161)	55.0%
REDWOOD PEDS, MEDICAL GROUP (27937)	83.3%	MARIN COMM, CLN SAN RAFAEL (22856)	54.2%
TULELAKE, HEALTH CENTER (27928)	83.3%	SALUD, CLINIC (6930)	54.2%
SUTTER MEDICAL, GROUP YOLO (3793)	82.4%	ADVENTIST HLTH, CLEARLAKE (26806)	53.3%
ROHNERT PARK, HEALTH CENTER (35718)	82.1%	FORTUNA COMM, HEALTH CENTER (32561)	53.3%
LASSEN, MEDICAL CLINIC (39300)	80.0%	TRINITY COMM, HEALTH CLINIC (27964)	53.3%
HUMBOLDT OPEN, DOOR CLINIC (2520)	79.4%	FAIRCHILD, MEDICAL CLINIC (26862)	52.7%
EUREKA COMM, HEALTH CENTER (3946)	78.4%	SOLANO COUNTY, HLTH SVC (26994)	48.1%
WOODLAND, CLINIC (2221)	78.2%	COMMUNITY MED, CNTR VACAVILLE (10992)	47.2%
LITTLE LAKE, CLINIC (12602)	77.8%	GRAVENSTEIN, COMM HLTH CTR (32901)	46.7%
HANSEN FAMILY, MEDICAL CENTER (4860)	76.9%	HEALTHPLAN, SOLANO (HEALTHPLAN)	46.7%
ANDERSON, FAMILY HLTHCTR (17323)	75.0%	ADVENTIST HLTH, CLEARLAKE (26800)	46.6%
WOODLAND, CLINIC (6932)	75.0%	REDDING RANCH, TRINITY HEALTH (42097)	43.8%
MERCY FAMILY, PRACTICE CLN (27956)	75.0%	CHURN CREEK, HEALTHCARE (35929)	42.9%
SHASTA COMM, HEALTH CENTER (27942)	74.7%	OLE, HEALTH (36802)	41.2%
HILLSIDE, HEALTH CENTER (22854)	74.5%	LA CLINICA, NORTH VALLEJO (18926)	35.9%
SRCH DUTTON, CAMPUS (46609)	73.3%	ANDERSON, WALK IN CLINIC (17977)	35.3%
LAKEVIEW, HEALTH CENTER (3853)	70.8%	ALLIANCE, MEDICAL CENTER (5062)	33.3%
BAECHTEL CREEK, MEDICAL CLINIC (22859)	70.4%	OLE, HEALTH (23435)	31.6%
PETALUMA, HEALTH CENTER (14857)	69.2%	SOLANO COUNTY, HLTH SVC (1034)	29.6%
SONOMA PLAZA, PED MED GRP (15638)	69.2%	OLE, HEALTH (3823)	26.4%
SUTTER MEDICAL, GROUP YOLO (3699)	69.2%	DIXON FAMILY, PRACTICE (1004)	22.7%
MODOC, MEDICAL CLINIC (28003)	68.8%	LA CLINICA, VALLEJO (11975)	21.9%
SRCH LOMBARDI, CAMPUS (9828)	67.7%	KIMAW, MEDICAL CENTER (28020)	19.0%
SHASTA LAKE, FAM HLTH CNTR (27935)	67.5%	SONOMA COUNTY, INDIAN HEALTH (16716)	18.8%
MENDOCINO, COAST CLINIC (4361)	66.7%	LAKE COUNTY, TRIBAL HEALTH (13848)	14.3%
SOLANO COUNTY, HLTH SVC (27776)	66.7%	KARUK TRIBAL, HEALTH PROGRAM (28007)	13.3%
VISTA FAMILY, HEALTH CENTER (18932)	64.7%	LAKE COUNTY, TRIBAL HEALTH (35717)	0.0%
POTAWOT, VILLAGE UIHS (27336)	64.3%		
BURNEY, HEALTH CENTER (27934)	63.2%	Rate for all PHC members	55.3%
HEALTHPLAN, SONOMA (HEALTHSONO)	62.5%		
SUTTER LKSIDE, MED PRACTICE (9505)	61.5%		
MARIN COMM, CLN NOVATO (18385)	60.0%		

PCPs above the 50<sup>th</sup> NCQA percentile for Medicaid are in green, those between the 25<sup>th</sup> and 50<sup>th</sup> are in blue, those in yellow and red are below the 25<sup>th</sup> percentile. Numerator Compliant = rapid test or culture done in association with prescription of antibiotics for streptococcal pharyngitis.

## PHC CalAIM Grant Program

DHCS has provided funding through the CalAIM Incentive Payment Program (IPP) to support the launch and sustainability of CalAIM's Enhanced Care Management (ECM) and Community Supports (ILOS). We anticipate that ECM and Community Supports may require significant investments in care management capabilities, infrastructure, information technology/data exchange, and workforce capacity. The PHC CalAIM Grant Program is one avenue for providers to apply for the funds necessary to support

their efforts. The grant program will span three program years with Program Year 1 (January 1, 2022 to December 31, 2022) focusing on three priority areas for funding:

**Priority Area 1: Delivery System Infrastructure**

To strengthen the data exchange infrastructure of ECM and Community Supports providers.

**Priority Area 2: ECM Provider Capacity Building**

To increase ECM provider capacity and abilities.

**Priority Area 3: Community Supports Provider Capacity Building and Take-up**

To increase Community Supports provider capacity and abilities.

**Application Process**

Utilizing the PHC CalAIM Grant Program application, each applicant will select one or more priority areas to invest in over the Program Year 1. The first round of application submission and review timeline is as follows:

<b>Deliverable/Activity</b>	<b>Timeline</b>
<b>Application Submission Period</b>	March 10 through April 7, 2022
<b>Application Evaluation Period</b>	April 8 through May 3, 2022
<b>Grantee Approval Announcement</b>	May 6, 2022

*Note: PHC will host a second round of grant awards beginning May 2022 to align with the rollout of CalAIM Phase 2 implementation.*

**Informational Webinar**

PHC is offering an informational webinar on March 9, 2022 at 1 p.m. Click [here](#) to register.

**Questions**

Contact the CalAIM Grant Program team: [grants@partnershiphp.org](mailto:grants@partnershiphp.org).

**Resources for Long Covid**

"Long-Covid," also referred to as post-Covid conditions, post-Covid syndrome, or post-acute sequelae of SARS-CoV-2 infection (PASC), generally refers to symptoms that develop during or after acute Covid-19 illness, continue for ≥2 months (or 3 months from symptom onset), and are not explained by an alternative diagnosis. It is not yet known whether "long-Covid" represents a new syndrome unique to Covid-19 or overlaps with recovery from similar illnesses.

Studies with different methodologies suggest that about 10% of individuals who recover from Covid had prolonged symptoms.

Persistent physical symptoms following acute Covid-19 are common and typically include fatigue, dyspnea, chest pain, and cough. Headache, joint pain, dysgeusia, myalgias, diarrhea, and persistent neurologic symptoms have also been reported. Common psychological and cognitive symptoms include poor concentration, insomnia, anxiety, and depression. The time to symptom resolution depends primarily on premorbid risk factors, the severity of the acute illness, and the spectrum of initial symptoms. However, prolonged symptoms are common even in patients with less severe disease who were never hospitalized.

Treatment for post-Covid conditions depends on the nature and severity of the symptoms. Since such treatments should be studied for efficacy, referral to a tertiary care institution for clinical trials is recommended, if the symptoms are severe or prolonged. UCSF, UC Davis, and Kaiser have special clinical programs focused on post-Covid conditions, but there are long waiting lists, so in most cases PCPs must become proficient in managing these patients.

## Supporting Youth who are Expressing Distressed or Challenging Behaviors

### Youth who qualify:

- Current and former foster youth, and youth at risk of entering the foster care system.
- Neurodevelopmental disorder or traumatic brain injury with mild to severe trauma, mental illness or complex/impactful behaviors. In need of psychiatric and/or behavioral intervention.
- Youth ages 3 and above, including transitional aged youth.

The California Department of Social Services' (CDSS) Care Branch is offering fully funded case consultations for youth with Intellectual and Developmental Disabilities (I/DD). Help is available for counties, providers, resource families, and all partners.

Contact the CDSS: [CCR@dss.ca.gov](mailto:CCR@dss.ca.gov). Be sure to write "Case Consultation Referral," in the subject line.

[More Information](#)

## Connected Care Accelerator: Equity Collaborative

***Deadline for applications: March 16, 2022***

In partnership with the California Health Care Foundation (CHCF) and Cedars-Sinai, the Center for Care Innovations (CCI) is launching a new program designed to reduce disparities in telehealth care called the **Connected Care Accelerator: Equity**

**Collaborative.** This collaborative will improve access to telehealth for patients in historically underinvested communities.

Participating organizations will receive \$75,000, access to monthly coaching, an online learning community, virtual convenings, and tools to reduce and/or eliminate disparities in access to telehealth. All participating organizations will focus on at least two of the following areas:

- Improving the use of video telehealth
- Supporting patients with digital barriers
- Expanding access to telehealth for patients with a preferred language other than English

[More information & application](#)

## PHC Educational Opportunities and Events

### *In-Person Regional Medical Directors Meetings Planned*

Living with endemic Covid requires us to continue to find ways to safely meet with each other while in person. The dialogue, discussion, and relationship building that comes from meeting and interacting with each other is vital in sharing ideas, developing new partnerships, as well as to nurturing our emotional well-being and professional fulfillment.

The California Department of Public Health (CDPH) model predicts Covid infection rates in March and April 2022, will drop to levels we were seeing in the autumn of 2021.

With this in mind, we are pleased to announce that our 2022 Regional Medical Directors meetings will be in person! Dates and registration links are as follows:

**Date:** Friday, March 11, 2022

**Time:** 9 a.m. - 2 p.m.

**Location:** Redding, CA at the Red Lion Inn

**Registration:** [In-person only](#)

**Date:** Friday, March 18, 2022

**Time:** 9 a.m. – 2 p.m.

**Location:** Ukiah, CA at the Ukiah Conference Center

**Registration:** [In-person only](#)

**Date:** Friday, March 25, 2022

**Time:** 9 a.m. – 2 p.m.

**Location:** Eureka, CA at the Sequoia Conference Center

**Registration:** [In-person only](#)

**Date:** Friday, April 8, 2022

**Time:** 9 a.m. – 2 p.m.

**Location:** Fairfield, CA at PHC's Conference Facility

**Registration:** [In-person](#) or [Virtual](#)

Note that the final session in Fairfield will be a hybrid format, for those unable to attend any of the other events in person.

**Updated Covid Safety Precautions:** We are committed to have sufficient precautions that the risk of any Covid transmission at the event is miniscule. We ask that you only attend if you have no symptoms of respiratory infection or other potential Covid symptoms, and are not under current quarantine for Covid exposure or isolation for Covid infection. We ask all attendees to wear a highly effective mask, such as KN95, KF94, N95, or equivalent while indoors. Indoor seating will be 6-12 feet apart. Most locations will be serving an outdoor lunch, with a minimum of 3 feet distance between each other, so you can catch up with your colleagues.

Expect our usual agenda topics: new PHC policies, clinical updates, quality measure updates, state policy updates, public health updates.

Please join us and your colleagues! Save the date and sign up now!

## Accelerated Learning Education Program Webinars

**CME/CE's Available, see linked flyers for more details.**

**Target Audience:** Clinicians, practice managers, quality improvement teams, and staff who are responsible for participating and leading quality improvement efforts within their organization.

These learning sessions will cover Partnership HealthPlan of California's Primary Care Provider Quality Incentive Program measures.

### **Controlling High Blood Pressure**

[Flyer](#)

**Date:** Tuesday, March 15, 2022

**Time:** Noon - 1 p.m.

[Sign-up Now](#)

### **Early Cancer Detection (Cervical, Breast, and Colorectal Cancer Screening)**

[Flyer](#)

**Date:** Tuesday, April 12, 2022

**Time:** Noon - 1:30 p.m.

[Sign-up Now](#)

### **Pediatric Health - A Cluster of Services for 0 - 2 Years Old**

[Flyer](#)

**Date:** Tuesday, June 7, 2022

**Time:** Noon - 1 p.m.

[Sign-up Now](#)

## **Pediatric Health – Child and Adolescent Well-Care Visits (3-17 years), Screenings, and Immunizations for Adolescents**

[Flyer](#)

**Date:** Tuesday, July 12, 2022

**Time:** Noon - 1 p.m.

[Sign-up Now](#)

## **Update on Childhood Lead Poisoning Prevention**

Update on childhood lead poisoning prevention: counseling, screening, and management for children potentially exposed to lead.

Objectives:

- Discuss risk factors, clinical effects, management and treatment of childhood lead exposure
- Identify cultural risk factors for exposures in all socioeconomic groups
- Explain California’s childhood lead screening statuses and regulations, provider mandates, and the role of anticipatory guidance in prevention
- Outline health and environmental interventions for children with exposure, and services provided by state and local programs

**Date:** Wednesday, April 20, 2022

**Time:** Noon – 1:30 p.m.

[Sign-up now](#)

## **ABCs of Quality Improvement**

The ABCs of Quality Improvement (QI) is a virtual training designed to teach you the basic principles of quality improvement. The five-session course covers the followings topics:

- What is quality improvement?
- Introduction to the Model for Improvement
- How to create an aim statement (project goal)
- How to use data to measure quality and to drive improvement
- Tips for developing change ideas that lead to improvement
- Testing changes with the Plan-Do-Study-Act (PDSA) cycle

Who Should Attend? The course is designed for clinicians, practice managers, quality improvement team members, and staff who are responsible for participating and leading quality improvement efforts within their organization.

**Dates:** May 18 and 25; June 1, 8 and 22 from noon to 1 p.m.

**Registration:** [Open on April 1](#)

## **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](#).

Looking for more educational opportunities? The Quality & Performance Improvement department has many pre-recorded, on-demand courses available to you. Trainings include:

- The Role of Leadership in Quality Improvement Effort: Leaders from top performing organizations share how they were able to build a culture of quality.
- PCP QIP High Performers – How'd They Do That? Learn how other PCPs accelerated in their QIP performance.
- ABCs of Quality Improvement: An introduction to the basic principles of quality improvement.
- Accelerated Learning Educational Program: An overview of clinical measures including improvement strategies and tools.
- Project Management 101 – An introduction to the basic principles and tools used in project management.

You can find these on-demand courses, and more, on our [Webinars Webpage](#).

## Recommended Educational Opportunities Outside of PHC

### Emerging Stronger: Creating a New Normal

The Coalition for Compassionate Care of California will host its annual summit in person. Don't miss this the presentations by national thought leaders in advanced illness, palliative care and end-of-life issues. CME available.

**Dates:** May 4-5, 2022

**Location:** San Francisco Airport Hyatt Regency

**Full Agenda and Registration:** [Sign-up Now](#)

### VITAL: Relational Health, a New Learning Series for Pediatric Providers

#### CMEs Available

VITAL offers a free online, self-paced course of six modules, each approximately 20 minutes long

Lessons Available:

- Introduction to Relational Health
- The Science of Relational Health
- ACEs, Toxic Stress & Relational Health
- Relational Health as a VITAL sign
- How to Support the Relational Health of Children & Families
- Culture & Relational Health

[More information & registration link](#)