Weekly Medical Directors Briefing
December 14-18, 2020

**"Nothing in life is to be feared, it is only to be understood.
Now is the time to understand more,
so that we may fear less."
-Marie Curie**

Our Role in Addressing Fear of COVID Vaccination

Recent surveys have found that physicians are largely inclined to use the new COVID-19 vaccinations (80-90%), while nurses are much less inclined (30-50%), which is lower than the rate in the general public (about 60%). What is the cause of such hesitancy?

The quote above from Marie Curie, two-time Nobel Prize winner for her discovery of radioactivity and radioisotopes, is apropos to answering this question.

On the surface, the appeal to use understanding to over come fear would seem to invoke using vaccine study data to overcome vaccine hesitancy. There is also an element of idealistic recklessness (or courage?) in this quote, since Marie Curie died of aplastic anemia, likely brought on by the radiation that she first described as a scientist. Given how little was known about radiation at the time, much less its effect on humans (DNA was identified as the basis of genetics decades later) it is perhaps not surprising that she was unafraid of radiation. In the end, her drive to generate new knowledge and understanding of the subatomic world was stronger than her fear of potential risks that would not be defined until the future.

Rosalind Franklin was another physicist to die of radiation exposure, in the pursuit of understanding. Her exquisite X-rays of crystalized DNA were the basis of determining that DNA formed a double helix, which allowed Watson and Crick to theorize on its structure. If she hadn't died, she would have likely been a co-winner of the Nobel Prize for this work. But if she hadn't persisted in doing radiograph after radiograph (and getting exposed), Watson and Crick would not have had the key information needed to sort it all out.

If Marie Curie had been as afraid of radioactivity as she probably (in retrospect) should have been, the nature of radiation would not have been understood for many years later. She may have lived some years longer, but her important contributions to physics would have had to wait for others to work out. I think her statement above was a reflection of courage, with some subconscious knowledge of the unknown risks, but she felt the work was so important that it outweighed these unknown risks.

The decision to use a new vaccine carries a similar balance of hopefulness and caution: vaccinate sooner to help break the cycle of infection, but potentially be exposed to a risk that is not known at this early time.

New vaccines have a long history of being treated with suspicion at first, so there is an evidence base on what helps increase vaccination rates in this setting. Interestingly, long explanations of all the ways the vaccine has been studied and found to have side effects less severe than the risk of natural infection is NOT very

effective. This approach is still important, but we must realize it will not lead to mass acceptance of the vaccine.

So what does work?

Having famous, well-liked or well-respected people publicly get vaccinated and speaking up about why they are doing so is very effective. In 1956, Elvis Presley rolled up his sleeve on national television to receive the new polio vaccine. Historians say this helped increase the acceptance of this vaccine and the rate of adoption.

Making vaccination easy and matter-of-fact is another helpful tactic. Allowing social communities (like schools, churches, hospitals, and health centers) to be vaccinated as a group also increases overall vaccination rates. The combination of convenience and subtle social pressure helps overcome ambivalence.

As leaders, we can use both these strategies in our communities. Find trusted opinion-leaders (including you, the medical leaders in your community) to publicly get vaccinated and speak about it. Make it easy, make it social.

Never in human history has a vaccine been introduced so quickly nor in the face of such a raging pandemic. There may be more risk than we are aware of now, but there are compelling benefits to balance this, as a society, as healthcare leaders and as individuals.

This Week's News

Standards for Screening for Syphilis in Pregnancy

Case study: A 25-year-old woman who denies history of drug use, and has one sexual partner, gives birth to a baby diagnosed with congenital syphilis. The mother had a negative RPR at the initial blood test in the first trimester, but no follow-up RPR tests were done because the prenatal care provider did not identify any risk factors. She was seen in the emergency department at 34 weeks gestation for dizziness; she was given IV fluids and sent home.

What new recommendation by the CDC and CDHP could have prevented this case of congenital syphilis?

Rising syphilis rates (five-fold increase in six years) are now leading to increased numbers of newborns diagnosed with congenital syphilis (a nine-fold increase in six years). This is completely preventable with antibiotic treatment of the mother before delivery.

Previously, all major expert groups recommended universal screening of pregnant women for syphilis at the first prenatal visit, and repeat tests if a woman was at an increased risk of acquiring syphilis during pregnancy.

The new standard, just released by the California Department of Public Health, is to have *all* women receive a second screening test for syphilis (the RPR test) in the early third trimester (in our region, this was previously only recommended in Shasta County). This may be combined with the screening test for gestational diabetes if needed, for logistical reasons. In addition, most pregnant women are recommended

to have a repeat RPR when they arrive in labor, unless they have documented low risk of infection AND they have a recent negative test in the third trimester.

Risk factors for syphilis infection include:

- *Any* recreational drug use, especially methamphetamine use or IV drug use
- *H*omelessness or unstable housing;
- Limited or no prenatal care
- Incarceration in the past 12 months and/or having a partner who was incarcerated in the past 12 months
- Reported sex exchange
- Current or past infection with any other sexually transmitted illness, including pelvic inflammatory disease
- Having multiple sexual partners, or a single partner with multiple partners.

If staff are not universally checking for these risk factors in the last trimester, ordering a routine RPR with hospital admission labs would be advisable.

Finally, CDPH is recommending that emergency departments routinely screen pregnant women for syphilis if they come to the emergency room or are newly incarcerated in correctional facilities, and there is not a recent negative test available.

Screening 2 to 6 Year Olds for Elevated Lead Levels

Case study: A parent brought in their 4-year-old PHC member for a health maintenance examination. The physician discovers that the child has never had a lead screening test as an infant. What should the clinician do, according to the CDC and the CDPH?

1. Since there are no old homes in the area, no need to ask questions or screen the child.
2. Screen for exposure to lead, and not screen the child if no risk factors are found.
3. Order a capillary or venous lead level.

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, as well as the options for screening methods available.

In this weekly newsletter we will review requirements and recommendations in screening for 2- to 6-year-olds.

For children age 2 to 6 years, who have *not* had a lead test *after* age 24 months, a single lead test should be ordered. This is the age range in which there is higher risk of elevated blood lead levels, and also the age in which mild elevations in blood lead is associated with long-term cognitive deficits.

Parents of children aged 2 to 6 years, with a *normal* lead screening test *after* age 24 months, should answer questions to ensure they are not having new exposures to lead. While CDPH does not have an official screening form, here is one from South Carolina. If a new exposure is found, lead screening is indicated.

Finally, if a child has a history of previous elevated blood lead levels, follow-up testing is indicated after environmental mitigation activities were completed, as directed by your local county health department.

The correct answer to the case above is number 3. Having Medicaid (through PHC) – as a proxy for family income level - is considered a risk factor for elevated lead levels in the United States, and state and federal policy/law require routine screening with catch-up screening if no timely screening has been done.

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 approval, 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 (Benadryl) 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.

Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experinces, Toxic Stress, and Health

The Office of the California surgeon General released the first California Surgeon General's Report – roadmap for Resilience: ***The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health***. The report serves as a blueprint for how communities, states, and nations can recognize and effectively address Adverse Childhood Experiences (ACEs) and toxic stress as a root cause to some sort of the most harmful, persistent, and expensive societal and health challenges facing our world today.

A special webinar was held on December 10, 2020, where California Surgeon General Dr. Nadine Burke Harris shared key findings of the report along with critical

insights for policymakers, scientist, healthcare providers, educators, and advocates to advance evidence-based solutions and approaches to act now to prevent and health childhood adversity.

The webinar materials, including a recording of the broadcast, are available for viewing and download on the ACEs Aware Educational Events page.

Trauma-Informed Network of Care Roadmap Released for Public Comment

Deadline for public omment on the roadmap is January 15, 2021.

On December 14, 2020, the ACEs Aware initiative released a draft Trauma-Informed Network of Care Roadmap for public comment. The roadmap aims to provide practical steps that health care providers and heatlh and human services organizations can take within their own communities to grow cross-sector networks of care that support children, adults, and families in effectively mitigating the impact of ACEs and toxic stress on heatlh.

View the Roadmap
Public Comment Survey on the Roadmap

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 have type 1 diabetes or difficult-to-control type 2 diabetes AND not already 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 go 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 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.

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

- 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.
- 2020 PCP QIP High Performers - How'd They Do That: learn best practices from the 2019 PCP QIP high performers.

You can find these on-demand courses, and more, on our Webinars Webpage.

Project Management 101 Webinar

Flyer

This two-session webinar is an introduction to the concepts and tools used in project management. Participants will learn project management principles and the tools used in each phase to manage projects successfully.

Project Management – Session 1 of 2

Objectives:

- Introduce the concepts and tools used in project management
- Learn project phases and processes
- Understand steps in framing and planning projects

Date: Wednesday, February 03, 2021
Time: Noon – 1:15 p.m.
Sign-up Now

Project Management – Session 2 of 2

Objectives:

- Apply concepts from Session 1 in a group activity
- Learn the key points in executing and monitoring projects
- Understand how to successfully close and transition projects

Date: Wednesday, February 10, 2021
Time: Noon – 1:15 p.m.
Sign-up Now

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 – Application Due January 08, 2021

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 five 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

Learning Network – Application Due February 15, 2021

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.

Applied Motivational Interviewing Workshop

Motivational Interviewing (MI) has a strong evidence base for working with people who are ambivalent about behavioral change. 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 and 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