Weekly Medical Directors Briefing
May 16-20, 2022

"Listen with your eyes as well as your ears."

–Graham Speechley

Wake Up Your Mirror Neurons

In the days before virtual visits and patients wearing masks, I would enter the exam room by greeting the patient, smiling and looking at them. So much information is communicated in this way. With our demeanor, we can convey caring, respect, and dignity. The patient, in turn, communicates mood, level of confidence, social/language/economic status, and (importantly) understanding.

My visits with patients are now either virtual (video or phone) or in-person with both provider and patient wearing a mask to prevent potential COVID transmission. This is affecting my ability to assess the patient's mood and understanding, and makes it harder to quickly gain the trust of new patients.

Neuro-psychology experiments show that many human interactions (including social learning, empathy, and transfer of emotions) depend on the Mirror Neuron System of the brain. This system works best when a person experiences more complex sensory input. For example, a 2-dimensional view of a face on a video screen is less effective at influencing the Mirror Neuron System than an in-person interaction, where body posture, body motion, and context add meaning. The greater activation of the Mirror Neuron System when we are in the presence of others helps explain the excitement we now feel with interacting in-person with friends and colleagues, compared to previous video interactions.

The Mirror Neuron System also rapidly and unconsciously allows us to interpret the emotional state of others based on facial expressions. The eyes and the mouth are most expressive, so covering the mouth with a mask to prevent disease transmission decreases the information available to our Mirror Neuron System.

In many health care settings, routine mask wearing is still required. How can we make up for the loss of ability to see the facial expressions of the mouth? Interviews of women in countries where face coverings are common for religious reasons suggest three compensatory mechanisms that we can learn.

Eyes: First, learn to communicate emotion more effectively with our eyes. This takes a bit of practice. It requires us to spend a little more effort making eye contact and intentionality in connecting eye expression with emotional status.

Non-facial body language: Gait, character of a handshake, posture, and use of hand expressions can convey much emotional context. Clothing and grooming contain

additional clues. These are difficult to see over video visits, but can be very helpful for in-person visits where the patient is masked.

Voice: Verbal expressiveness can convey information lost when visual cues are not present. This can be more subtle, depending on language concordance, personalities and habits of the clinician and their patient. I have seen a few clinicians who have remarkable natural capacity to strongly connect with patients, even on phone visits. Most of us can learn to master our greeting of patients on phone or video visits to build a sense of trust and empathy. As the clinician starts thinking about the differential diagnosis, options for testing, how many patients are waiting, and any personal stressors, our verbal expressiveness may lose some of its empathic quality.

For an excellent and very readable review of the many ways we communicate non-verbally, see *The Power of Body Language*, by Tonya Reiman.

For leaders and managers engaging with co-workers and community partners, these same compensatory mechanisms can be used for virtual interactions, but at a price. The level of engagement from virtual conferences and meetings is often significantly compromised, resulting in less interactive dialogue, less productive debate, and less synergistic learning. In particular, partners and policymakers are not cooperating and solving problems as effectively. To overcome this, we must strive to leverage in-person interactions. If infection safety is a concern, we can meet outdoors (particularly good for meetings with a meal) or in a well ventilated indoor setting with sufficient distance to minimize risk of airborne infection but close enough to see each other's expressions and body language. Judicious use of rapid COVID antigen tests also has a role.

This is our new normal. We owe it to our patients, our organizations and ourselves to put our Mirror Neuron Systems back to work.

This Week's News

Congratulations to Top PCP QIP Performers

The Primary Care Provider Quality Improvement Program (PCP QIP) is Partnership HealthPlan of California's (PHC's) pay for performance program for contracted primary care offices.

For 2021, the average weighted score on the Core Measure Set was 58%, compared to 68.5% in 2020 and 48% in 2019. The scores ranged from a low of 5% to a high of 100%. A total of $33 million was distributed this year, to over 220 individual sites.

The following PCP sites scored 100% on the Core Measure Set:

- Sonoma Plaza Pediatrics Medical Group
- Martha Cueto Salas (Pediatrician in Petaluma)
- Annadel Medical Group: Rohnert Park and 505 Doyle Park Dr., Santa Rosa
- Marin Community Clinics, Greenbrae

The following PCP sites also scored over 90% on the Core Measure Set:

- Davis Community Clinic (CommuniCare)
- Shasta Family Care
- NorthBay Center for Primary Care: Vacaville and Green Valley sites
- Petaluma Health Center: Petaluma and Rohnert Park sites
- Santa Rosa Health Centers: Pediatric and Elsie Allen Campuses
- Alexander Valley Healthcare
- West Marin Medical Center

PHC's PCP QIP is a challenging set of measures. We recognize the significant effort and attention to quality needed to perform so well.

Influenza Increases Lead to Additional Recommendations for High Risk Patients

The California Department of Public Health (CDPH) is notifying health care providers that seasonal influenza activity is gradually increasing, with elevated activity in Central California. This advisory provides guidance regarding vaccination, testing, and antiviral treatment in the context of co-circulation of influenza and SARS-CoV-2. Influenza vaccination remains reasonable, especially for persons at high risk of severe influenza. Influenza testing and influenza antiviral treatment are recommended in specific clinical scenarios.

Key Messages

- Seasonal influenza activity in California has been increasing gradually for several weeks. Activity is elevated in Central California.

- Influenza A (H3N2) viruses are predominant, but influenza B viruses have also been detected.
- Influenza hospitalizations are also increasing.

- If influenza vaccine is still available, continue to recommend:
  - Influenza vaccination, particularly to patients at high risk of severe influenza.
  - Co-administration of influenza and COVID-19 vaccine when patients present for either vaccine separately.

- Testing:
  - In general, all persons tested for influenza should also be tested for SARS-CoV-2.
  - Inpatient and congregate settings: Test all persons with respiratory illnesses.
  - Outpatient settings: Test all persons with respiratory illness for SARS-CoV-2. Test for influenza when it will affect clinical management or infection control.

- Provide influenza antiviral treatment as soon as possible to any patient with confirmed or suspected influenza who is:
  - Hospitalized;
  - At higher risk for influenza complications; or
  - Developing progressive illness.

- For high-risk persons with influenza-like illness:
  - Test for both influenza and SARS-CoV-2.
  - Start influenza antiviral treatment immediately. Do not wait for laboratory confirmation.
  - If the patient tests negative for influenza, discontinue influenza antiviral treatment.
  - If the patient tests positive for SARS-CoV-2, SARS-CoV-2 treatment (either with an anti- SARS-CoV-2 monoclonal antibody or authorized antiviral treatment) should be considered in outpatients at high risk for disease progression as outlined in product EUAs.
  - Treat both influenza and SARS-CoV-2 when co-infection is present.

- Suspected or laboratory-confirmed influenza outbreaks in long-term care facilities should be reported to the local health department. Mitigation measures, including influenza antiviral post-exposure prophylaxis may be recommended.

Infant Formula Shortage: Options for Parents Who Can't Find It

There are many voices out there with conflicting recommendations. A pediatrician-run site healthychildren.org offers these recommendations:

1. **Check smaller stores and drug stores**, which may still have some supply when the bigger stores are out.
2. **Buy formula online**, if you can afford it. Use well-recognized distributors and pharmacies and carefully check what you are buying (consult someone with health care background if not sure).
3. **Switch formulas.** For most babies it is OK to switch to any available formula, including store brands, unless your baby is on a specific extensively hydrolyzed or

amino acid-based formula such as Elecare (no store brand exists). Ask your pediatrician about recommended specialty formula alternatives available for your baby.

4. **Check social media groups.** There are groups dedicated to infant feeding and formula, and members may have ideas for where to find formula. Make sure to review any advice with your pediatrician.

Some specific dos and don'ts:

Don't:

1. Water down formula.
2. Give Almond mild, soy milk or other plant-based "milks."
3. Make your own, home-made formula using a recipe.

Do: In a pinch for short-term use only, with nothing else available, you may substitute:

1. Toddler formula for infant formula.
2. Whole cows milk, for 6 month to 12 month olds (with iron supplementation).
3. Once FDA approves them: formula imported from outside the U.S.

Toolkit to Advance Racial Health Equity in Primary Care Improvement

HealthBegins has partnered with the California Improvement Network (CIN) to create a toolkit to advance racial health equity in primary care improvement.

Effectively integrating equity into healthcare improvement efforts is a key focus of CIN. This new toolkit offers concrete, practical approaches and resources to help healthcare organizations—including those that provide, pay for, or support primary care—to increase quality improvement efforts that center racial health equity. Case studies provide insights into how organizations have implemented improvements.

We encourage you to read it, share it, and use it!

Up to $25k Kids VaxGrants Available

Applications Due May 27, 2022, or until all funds are disbursed. Act fast!

The State of California is offering grant funding to medical organizations enrolled in the federal Vaccines for Children (VFC) Program, serving eligible children from birth through 18 years of age. Administered by Physicians for a Healthy California, the California Department of Public Health (CDPH) is investing approximately $10 million to fund the KidsVaxGrant.

- **VFC providers newly enrolled in California's COVID-19 vaccine program (myCAvax) could be eligible for $10,000** to support enrollment and launching a vaccination center. Those that enroll in myCAvax from December 17, 2021, through May 27, 2022, will qualify for the grant.
- **VFC providers already enrolled in myCAvax, who are expanding operating hours could be eligible for $15,000**. Eligible providers must

expand hours of operations by a minimum of 15 hours to provide additional time options for working families.
    - Expanded hours must be outside of normal or existing clinic hours, and they must be completed within 60 days of the application's approval (not retroactive).

More information:

- KidsVaxGrant
- VFC Provider webpage
- Apply Now

Pre-exposure Covid Prophylaxis with Tixagevimab/Cilgavimab (Evusheld)

Previously approved treatments for Post-Exposure Prophylaxis after exposure to Covid are not effective against Omicron and are therefore no longer approved.

Certain individuals at high risk of morbidity and mortality from Covid are candidates for Pre-Exposure Prophylaxis with Tixagevimab/cilgavimab (Evusheld).

Evusheld is authorized for the emergency use as pre-exposure prophylaxis (PrEP) for prevention of COVID-19 in certain adults and pediatric patients (12 years of age and older weighing at least 40 kg). Health care providers should only administer it to individuals who are not currently infected with SARS-CoV-2 and who have not had a known recent exposure to someone infected with SARS-CoV-2. Evusheld is only authorized for those:

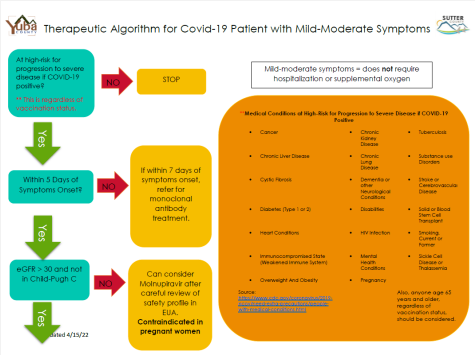
1. who have moderate-to-severe immune compromise due to a medical condition or who have received immunosuppressive medications or treatments and may not mount an adequate immune response to COVID-19 vaccination, or
2. for whom vaccination with any available approved or authorized COVID-19 vaccine is not recommended due to a history of severe adverse reaction (e.g., severe allergic reaction) to a COVID-19 vaccine(s) and/or COVID-19 vaccine component(s).

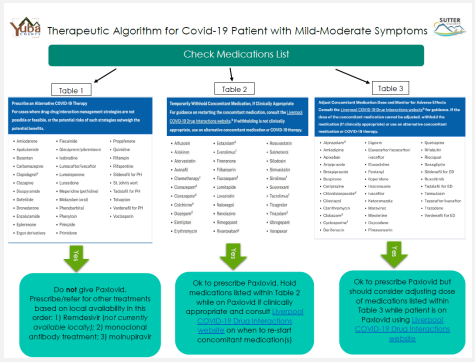
Typically, the first group includes those who have had organ transplants, are undergoing cancer chemotherapy, and those taking a variety of medications that suppress the immune system.

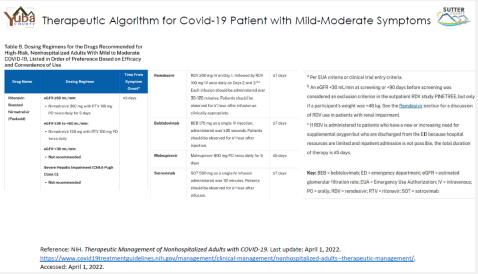
We encourage you to use your electronic health record system to search for appropriate candidates and work with your local county health department to arrange this preventive treatment. It is not clear how well this treatment lasts for Omicron; several months or protection is likely. See the FDA website for up to date information on this.

Covid Treatment Algorithm

The Public Health Officer of Yuba/Sutter Counties, Dr. Phuong Luu, put together a nice algorithm for treatment options for Covid, reproduced here:







(click on images for larger view)

Integrating Covid Therapies: FDA Approved and Off-Label (But Evidence-Based)

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 National Institutes of Health (NIH) still has information on prioritization of treatments on its website.

As Omicron has subsided, the available supply of medications to treat Covid has grown faster than the demand for its use; there is plentiful supply. In spite of this, many patients who would benefit from treatment are not being offered treatment by their

clinicians. Many counties are turning away supplies of Sotrovimab and Bebtelovimab, as they had run out of room to store the doses they have.

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 Centers for Disease Control and Prevention (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.

In addition to the FDA EUA approved medication options, two off-label oral medications (Fluvoxamine and inhaled Budesonide) have been shown by good studies to be beneficial. The Ontario Medical Association has provided a Clinical Practice Guideline Summary on the Recommended Drugs and Biologics in Adult Patients with Covid, which indicates the recommended therapeutic recommendations depending on a matrix of risk factors and vaccination statuses.

Here is one suggested order of use of these treatment options, which could be modified based on availability of drugs and preference of delivery method (e.g. oral vs. IV)

1. Paxlovid (oral)
2. Soltrovimab (IV)
3. Remdesivir (IV)
4. Bebtelovimab (IV)
5. Fluvoxamine (oral)
6. Budesonide (inhaled)
7. Molnupiravir (oral)

The California Medical Association (CMA) has a 25 minute presentation on therapeutic options accessible for CMA members, Virtual Grand Rounds: Covid Therapeutics.

A proposal by the federal government to make these treatments available in pharmacies without physician prescription 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.

Supporting Youth who are Expressing Distressed or Challenging Behaviors

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.

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.

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

More Information

PHC Educational Opportunities and Events

Virtual ABCs of Quality Improvement

Flyer

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.

Session 2 of 5: Using Data for Quality Improvement

Date: Wednesday, May 25, 2022
Time: Noon – 1 p.m.
Sign-up Now

Session 3 of 5: How Do We Know That a Change is an Improvement?

Date: Wednesday, June 01, 2022
Time: Noon – 1 p.m.
Sign-up Now

Session 4 of 5: What Changes Can We Make That Will Result in Improvement?

Date: Wednesday, June 08, 2022
Time: Noon – 1 p.m.
Sign-up Now

Session 5 of 5: Testing Change Ideas – Plan-Do-Study-Act (PDSA)

Date: Wednesday, June 22, 2022
Time: Noon – 1 p.m.
Sign-up Now

**The AAFP has reviewed ABCs of Quality Improvement, and deemed it acceptable for AAFP credit. Term of approval is from 5/18/2022 to 5/18/2023. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Credit approval includes the following session(s): 1.00 In-Person, Live (could include online) AAFP Prescribed Credit(s): 1)Introduction to Quality and Goal Setting; 2)Using Data for Quality Improvement; 3)How Do We Know That a Change is an Improvement;*

4)What Changes Can We Make That Will Result in Improvement; 5)Testing Change Ideas (PDSA).

***Provider approved by the California Board of Registered Nursing, Provider Number CEP16728, for 1.00 contact hours per session.*

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 PHC's Primary Care Provider Quality Incentive Program measures.

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

Using Lean and A3 Thinking to Manage Improvement Projects

This course will provide an introduction to Lean Thinking and how improvement teams can use the A3 tool to manage the full cycle of an improvement project from planning, monitoring, and sharing what you are leaning.

Target Audience: Quality improvement staff, team leaders, managers, and front-line staff.

Date: Wednesday, June 15, 2022
Time: Noon - 1:15 p.m.
Sign-up Now

Electronic Clinical Data Systems Webinar: Measure for PCP and Perinatal QIP

Electronic Clinical Data Systems (ECDS) is a HEDIS reporting standard for health plans collecting and submitting quality measures to NCQA. This reporting standard defines the data sources and types of structured data acceptable for use for a

measure. Data systems that may be eligible for ECDS reporting include electronic health records.

ECDS reporting is part of NCQA's larger strategy to enable a Digital Quality System and is aligned with the industry's move to digital measures. Here are the measures that will be covered in this webinar: (ECDS measures are indicated by a "-E" after the measure name.)

The following measures are currently ECDS measures:

1. Several Depression Related Measures: (DMS-E, DSF-E, DRR-E, PND-E, and PDS-E), including screening for depression in prenatal and postpartum periods, depression screening rates, appropriate follow up for depressed individuals, and improving depression symptoms.
2. Follow up care for children prescribed ADHD medication (ADD-E).
3. Breast Cancer Screening (BCS-E)
4. Unhealthy Alcohol Use Screening and Follow-up (ASF-E)

There is an ECDS Unit of service measure in the 2022 PCP QIP, in which PHC has hired a programmer to program the master code for these measures in two commonly used EHRs, eClinicalWorks and NextGen, to assist our PCPs with adopting this measure. Starting in 2023, the submission of ECDS supplemental data from electronic health records will be required for several PCP QIP measures, so using the 2022 unit of service measure to test out this process for your electronic health record is advisable.

In this webinar, we will go through the master code, supporting documentation, and answer questions about the measures and the process.

Who should attend: Configuration and reporting specialists for electronic health records in PCP and prenatal care practice settings, clinician champions of analytics, quality or medical informatics. If you have a vendor that supports your work in this area, they may attend.

Attendance limited to PHC providers (including their vendors), PHC staff, and PHC-invited guests.

Date: Tuesday, June 28, 2022
Time: Noon to 1 p.m.
Sign-up Now

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

Clinical Leadership Coaching through Western Clinicians Network

The Western Clinicians Network (WCN) is now offering dedicated coaching services to support developing clinical leaders in their four-state service areas. Coaching services are designed to support both current and developing clinical leaders to build leadership and management skills, troubleshoot professional challenges, and establish self-care and professional boundaries so they can serve the safety net over the long-term. WCN's **Clinical Leadership Coaching** offers a team of multi-disciplinary provider leaders with experience in a variety of states and professional settings.

This program is a six-month initial engagement with the following phases:

- **Baseline Interview:** Use of a leadership assessment tool to gain performance and leadership input about the client.
- **Initial Coaching Session**: approximately 2 hours. Time will be used for assessments and to establish intentions and goals for the coaching engagement.
- **Continued Support**: Following the initial session, 10 coaching sessions approximately 1-hour in length scheduled by the client and coach. Flexibility in length and frequency based on client need.
- **Growth & Development Plan**: At the conclusion of the 6-month coaching engagement, the coach and client will jointly develop a personalized growth and development plan that includes professional growth, continued education, and self-care goals.

Program Cost

$5,000 for an initial six-month engagement, with flexible pricing models for continued engagement at varying levels of on-going support after that point.

More Information

- WCN's Clinical Leadership Coaching Webpage
- Program Brochure
- Meet the Coaches
- Contact WCN for more information or to start the process