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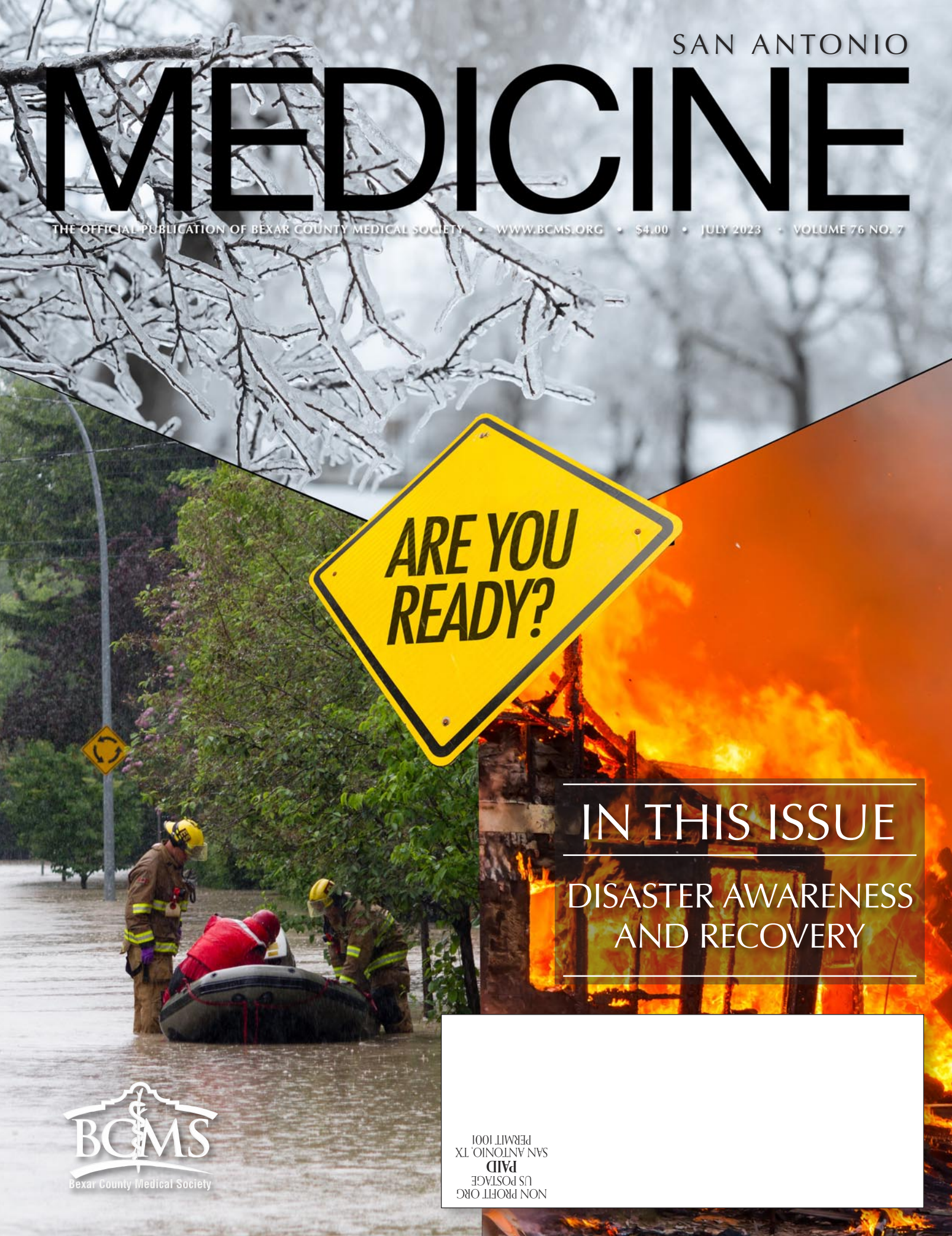

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DISASTER AWARENESS AND RECOVERY

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You will have access to this program when your policy renews beginning in May 2023.

Access the program at
www.tmlt.org/wellness

Travis CMS Safe Harbor Counseling Program
Available through a partnership with TMLT

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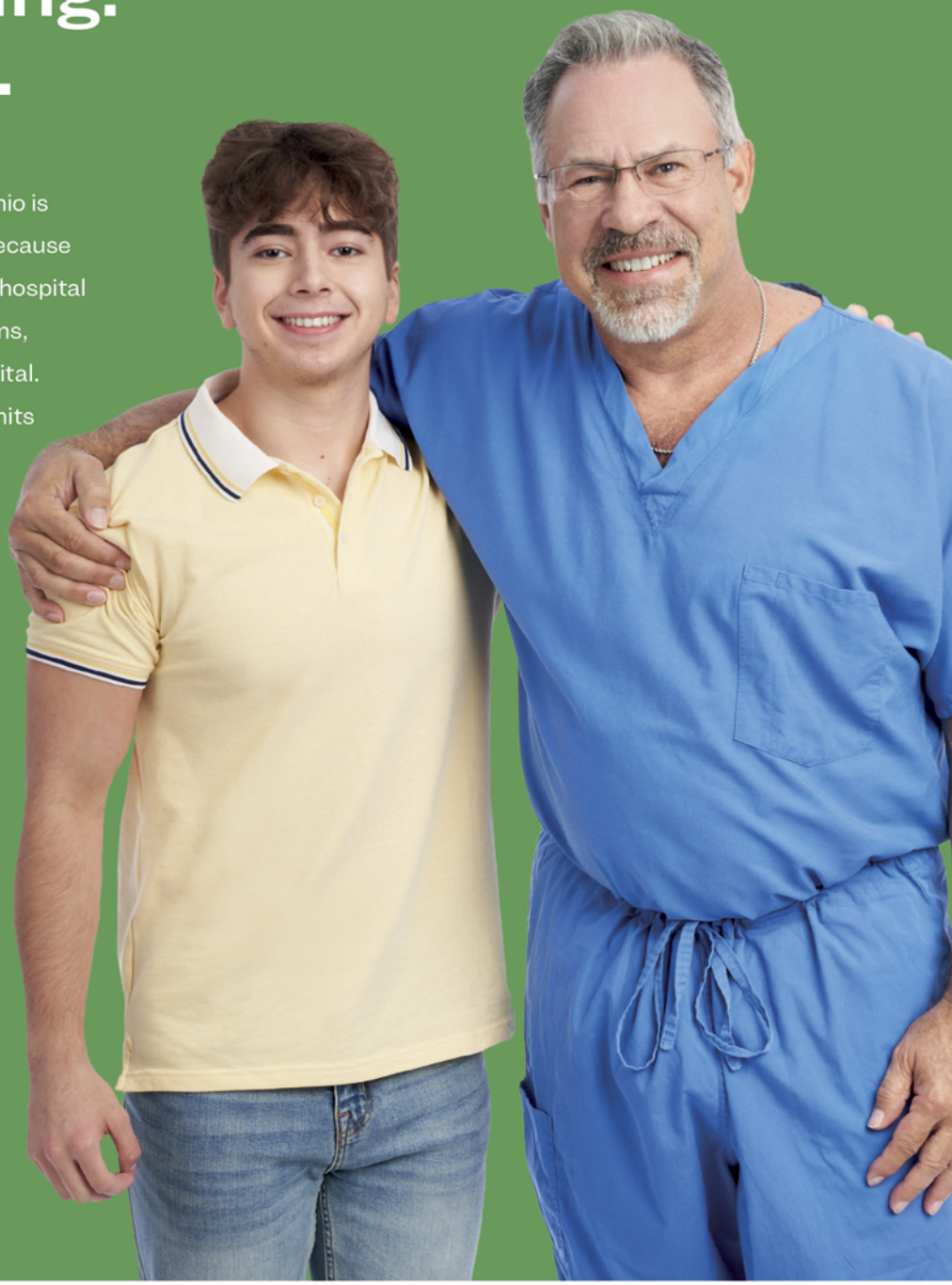

Hershel, Age 17
Brain Tumor Survivor

Dr. Mark Lee,
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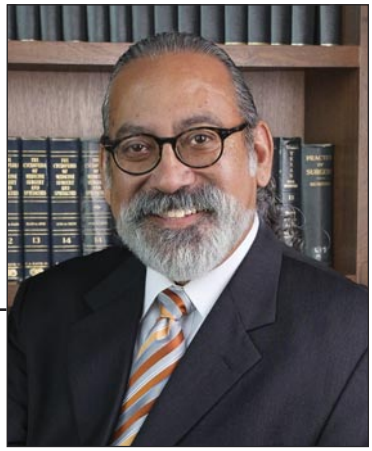

Are We Prepared Enough?

What About the Tsunami of Unmet Behavioral Healthcare Needs?

By John J. Nava, MD, 2023 BCMS President

With the arrival of June, hurricane season begins for another year. Luckily, Texas has not had to deal recently with a major hurricane landing on the Texas Gulf Coast. Even before Hurricane Katrina in 2005, the ritual of preparing for hurricane season occurred every summer. Since then, the best practices of emergency preparedness and disaster response have been honed in the field. Each season that passes informs the next step in studying and documenting these best practices.

When I last checked on the fiscal status of the Division of Emergency Preparedness at Metro Health, the story was a familiar one. Like so many pressing public health issues, the tragedy of Hurricane Katrina brought with it a massive initial Federal response. As time went on, and the effect of the response was appreciated, the urgency lessened, and it became difficult to maintain that level of Federal support. Frequently, as the next crisis develops, sometimes funds are redirected.

Then the pandemic happened. This worldwide event dwarfed a local weather event no matter how large. Though these hurricanes and typhoons are powerful and destructive, there is at least some opportunity to prepare. Using a checklist is one thing to do as the hurricane season starts. Many of these household guides have been professionally developed to reinforce the preparedness drill, so I won't try to summarize those messages. I direct people to online resources or printed material provided by community public health partners. San Antonio is far enough inland to serve as an evacuation resource for the Gulf Coast. Our San Antonio Metroplex has demonstrated its willingness to extend a helping neighborly hand in the past. We have been here before. This is nothing new. We will get through this.

Missed Alerts, Unheeded Warnings

I would like to suggest we may not have noticed an approaching tsunami whose arrival is imminent. The warning signs have been noted previously, but for some reason, the alerts have been missed or ignored. Things have been so bad for so long, perhaps message fatigue has set in. In September 2014, the Department of State Health Services (DSHS) was required to submit a report titled "The Mental Health Workforce Shortage in Texas," as required by House Bill 1023, 83rd Legislature, Regular Session. This bill was one of a series of bills to help address the state's mental health infrastructure and payment and delivery systems. House Bill 1023 charged the Texas Health and Human Services Commission (HHSC) with researching and analyzing the state's mental health workforce shortage, and this charge was passed on to DSHS. This agency, using existing information and data, reviewed the causes and potential solutions proposed for mental health workforce issues across Texas and the nation. This review revealed five possible key themes for state consideration and policy making:

1. Increasing the size of the mental health workforce
2. Improving the distribution of the mental health workforce
3. Improving the diversity of the mental health workforce
4. Supporting innovative educational models
5. Improving data collection and analysis

This report is packed full of data (existing at that time) demonstrating the great need for additional behavioral health workers, concentrating on ratios of patients to psychiatrists and psychologists, but also inclusive of other licensed core mental health providers. It documents how so many counties in Texas are Health Professional Shortage Areas (HPSAs) for mental health when these ratios are utilized, frequently cited as up to 80%.

Since it has been almost 10 years since this report was published, one might think that the workforce shortage has improved. After reading a recent report by the Commonwealth Fund, it is difficult to see whether or not things are improving. The gist of this periodic report grading our healthcare system is that the United States is "experiencing a behavioral health crisis: while the number of people with mental health conditions and substance use disorders is rising, many people cannot easily access the treatment they need. Two major contributors to this crisis are the shortage of behavioral health providers and limited insurance coverage for the services they provide. As in other areas of healthcare, people of color face more obstacles to behavioral healthcare than white people do, which worsens existing racial disparities."

More than one-third of adults report having a mental health condition or substance use disorder, but less than half of adults receive treatment for the condition because of provider shortages, high out-of-pocket costs, and gaps in coverage and reimbursement for behavioral health services. It has been estimated that the U.S. needs an additional 7,400 mental health workers to meet current needs. One way to

address this gap is to integrate primary care and behavioral health services. "In integrated practices, a team of primary care and behavioral health providers work together with patients and families to deliver care that addresses mental health, substance abuse and other medical needs. This holistic model differs from classic care models in which primary care providers (PCPs) refer to behavioral health providers when a need is identified but do not continuously coordinate their care. Several common elements exist across these models, including:

- Team-based care where multiple types of providers collaborate to address a range of patient care needs
- Universal screening for common behavioral and physical health disorders
- Shared information systems, such as electronic health records, to improve coordination across providers while maintaining patient privacy
- Measurement of patient outcomes using patient registries or tracking tools
- Engagement with social and community behavioral health services, such as opioid use treatment programs
- Individualized, person-centered care that incorporates family members and caregivers into the treatment plan"[1]

This is just the tip of the iceberg, but payment reform is another crucial component to addressing this provider shortage. These efforts are occurring at both the Federal and State levels, and may be helpful to support innovative practices. Of course, states that have allowed Medicaid expansion are able to direct additional resources to improve access. The response to address this mental health worker shortfall will take time to develop and nurture, will trigger public-private collaborations, and will likely resemble nothing like what people have imagined as the final product. Along the way, physicians should be ready to lead a multidisciplinary team and be willing to accept a different role than what we are accustomed to. Flexibility will be vital to eventual success.

Reference:

1. Nathaniel Counts, "Behavioral Health Care in the United States: How it Works and Where it Falls Short" (explainer), Commonwealth Fund, Sept. 7, 2022. https://doi.org/10.26099/txpy-va34

John J. Nava, MD is the 2023 President of the Bexar County Medical Society. He is interested in Primary Care, Clinical Research and Public Health.

Trying to Reason with Hurricane Season

By Brittany Garcia, BS, MHA, Vice President of Communication

Although I didn't attend medical school myself, as my husband's partner on this journey, boy do I remember some days and times clearly. Fortunately, or unfortunately for us, we weren't strangers to sacrifice, long-distance relationships or even danger, as he served in the Marine Corps during undergrad. So, when he decided he wanted to apply to medical school in the Caribbean, we both thought it would be a great option because he could start sooner instead of waiting for another application cycle in the U.S. Before we knew it, he flew to a small island called Saba. With each other's full support, he went to study and I stayed stateside to continue working.

For months our relationship was sustained by short phone calls due to awful internet connections and poor cell service as this was before FaceTime and a lot of other apps that make communication so much easier and enjoyable now. But since we were in it for the long run, we came to accept how it was going to be no matter how frustrating or unpleasant. Coming up on what would be the completion of his first semester, we planned to meet on Saba and make a vacation out of one of his breaks that summer. Unbeknownst to me at the time, our plans coincided with the early days of hurricane season.

On the day I was scheduled to leave, I was so excited, but as I was at the airport preparing to board, my husband gave me word that although he had just finished his last test, he might not be able to meet me when I arrived. The weather service was tracking a hurricane in our path. The dread set in immediately. Saba was so small that it required transport via ferry or by a much smaller plane. You couldn't get there on a commercial plane and I needed to reach the neighboring island of St. Maarten first. I might not make it to the ferry or be able to fly to Saba as planned if the weather conditions were bad. I even wondered if the current flight would be delayed or canceled. It wasn't. So, as the plane pushed back all I could think was, "Here I go to an island I've never been to, where I don't know a soul and I might be there the entire week completely alone. And oh yes, a hurricane might hit land too!" I was so worried about the unknown.

Since my husband wasn't confined to a plane for hours, he was able to take a more proactive approach, thankfully. He started reaching out to friends to see if he knew anyone that would be visiting St. Maarten during the break. That way if the worst were to happen, at least I wouldn't be alone in a different country. It turned out that a classmate and his girlfriend were already on St. Maarten. Then he proceeded to catch the last ferry boat leaving Saba to St. Maarten. When he got there, ferries had stopped and they were no longer transporting people to St. Maarten as the waters were already too choppy. Since the ferry wasn't going to be an option that day or the next, he raced to Saba's airport. He hoped he could fly to St. Maarten right away because time was ticking and weather conditions were worsening. By some miracle he was able to purchase the last remaining ticket on the last plane flying out that day. To my shock and amazement, he surprised me at the airport!

It was one of those magical moments where I knew I'd chosen the right person to spend my life with because instead of waiting around for me to arrive when I was due hours later, he figured out a way to get to me; to ensure my safety. We got lucky and that hurricane eventually took a different course back into the ocean until it dissipated.

Yes, medical school and residency have all presented challenges and made maintaining a relationship difficult. I'm no stranger to complaining about that, but that doesn't mean they also haven't been the source of some really fond memories.

If you are a physician or physician's spouse who would like to join the BCMS Alliance and exchange similar stories, or participate in our fellowship or philanthropy projects, please visit www.bcms-alliance.org.

Brittany Garcia, BS, MHA, is the 2023 Vice President of Communication for the BCMS Alliance.

John Lennon, one of the creative forces behind The Beatles, once offered those words of wisdom that ring true for all busy physicians.

One day into the next; medical school transitions into residency, residency into your first year in practice, and one day you are mid-career and realize how much “life” has happened, and how far you and your family have come. So much growth and progress. So much to protect.

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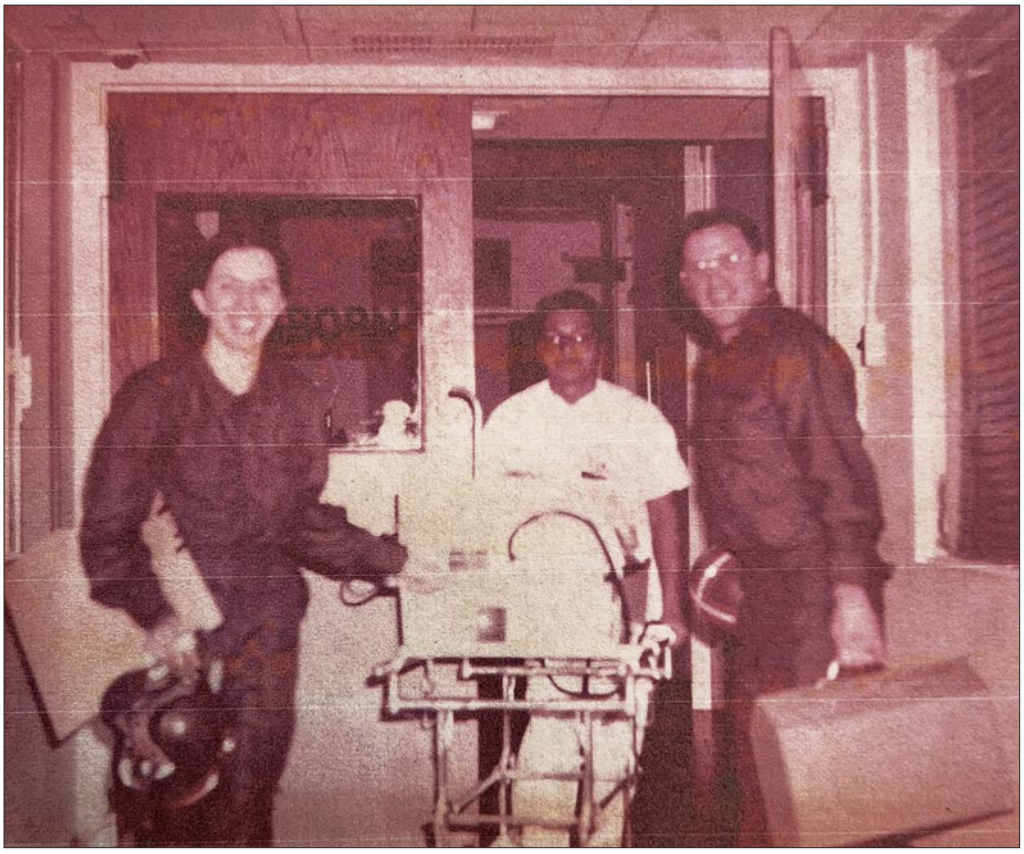
SCAN TO CALL

Early Neonatal Transport

To: Bexar County Medical Society
From: Dr. Melvin Baden, MD, (Col. MC Ret)



I read with some anticipation *Medical Missions* by Rachael Farner on "Transporting the Littlest Texans" in the latest *Medicine Magazine*, and having been there for the earliest neonatal transports, I thought I could add some information.

In reality, San Antonio and its neonatal intensive care facilities were very instrumental in the initial development of the safe transport for both critically ill neonates and the tiniest of premature babies. Wilford Hall Air Force Hospital, under the leadership of Dr. Robert DeLemos and his access to Scott Air Force Base, first used fixed wings (DC-9s) for the transport of pediatric and newborn patients. At the same time, the neonatal service at BAMC, with access to the Army's 507th Helicopter company, fostered the use of helicopters to quickly and safely transport critically ill neonates.

I vividly remember (picture from 1975 of me, Dr. Adrian Butler, a pediatric resident, along with a medical corpsman) heading out to a waiting chopper to pick up and transport an infant back to our NICU. The first choppers were ill-equipped to handle our transport isolette and ventilators, and had to rapidly alter their electronics and fuel storage to safely accommodate us. I very well remember sitting in the chopper directly next to a large extra fuel bladder!! Occasionally we would have to stop at a local military base to fully refuel.

Dr. DeLemos had recently modified a pediatric respirator to provide us with vital respiratory support. We provided neonatal transport to both civilian and military infants locally and throughout southwest Texas, Louisiana and Oklahoma. Occasionally we would use fixed wing aircrafts for more distant transports, and I remember flying in a DC-9 to a military hospital in Panama City, Panama, to pick up a critically ill neonate. Soon thereafter we developed neonatal transport programs at the Santa Rosa Children's Hospital and the Methodist NICU programs. Both hospitals rapidly developed well-motivated teams with trained doctors and nurses that would be on call 24 hours to transfer infants using choppers from the 507th and later private transport. We would carefully take off from the rooftops of the Santa Rosa and the Methodist Hospitals and return with our precious infants. Later Dr. Alejandro Gonzales served as director of the initial transport team and provided training and continuing education.

It was certainly a dangerous but rewarding experience to participate in the transport of these precious patients, and I feel privileged to have been a part of the important activity.

Dr. Melvin Baden, MD, (Col. MC Ret)

TMA House of Delegates

David N. Henkes, MD

Jennifer Rushton, MD

Jayesh Shah, MD

Ezequiel "Zeke" Silva, III, MD

Four San Antonio physicians were elected to represent Texas doctors as delegates to the American Medical Association (AMA) House of Delegates. Texas delegates to AMA vote on policy proposals and help shape healthcare policy to help all Americans. The Texas Medical Association (TMA) House of Delegates, the organization's policymaking body, elected the physician leaders in Fort Worth during TexMed, TMA's annual conference, which took place May 19-20.

David Henkes, MD, a pathologist in practice 40 years, was re-elected as an AMA delegate, and he will continue to chair the Texas Delegation.

Jennifer Rushton, MD, a pathologist with 16 years of experience, was elected as an AMA delegate.

Jayesh Shah, MD, an undersea and hyperbaric medicine specialist in practice 29 years, was re-elected as an AMA delegate. He also is a member of TMA's Board of Trustees, which elected him secretary.

Ezequiel "Zeke" Silva III, MD, a radiologist with 22 years of experience, was reelected as an AMA alternate delegate. He is also a member of the Bexar County Medical Society Board of Directors, where he serves as Treasurer.

TMA Leadership College

Jeniffer Okungbowa-Ikponmwosa, MD

Emergency Medicine
San Antonio

Gina M. Vento, MD

Emergency Medicine
San Antonio

The 2023 TMA Leadership College (TMALC) Class of 2023 was also honored at the recent TexMed. Fifteen individuals were selected for their leadership skills and making a positive impact on the field of medicine, two of which are members of the Bexar County Medical Society. During the year, the scholars meet to develop a deeper understanding of their own leadership strengths and weaknesses, expand their capacities to serve as leaders in organized medicine and their communities, and form lasting relationships with fellow physicians from around the state. Since 2010, TMALC has developed strong physician leadership in Texas with more than 250 TMALC alumni.

Bexar County Medical Society and our Local Emergency Preparedness Consortium

By Bryan M. Miller, MS, BSN, RN and David J. Cohen, MD, MPA, Chair of Alamo Area MRC

Most of us are familiar with disasters and response during them. Did you know that there are five mission areas of the disaster when working in Emergency Management? The Five Mission Areas[1] are defined from Federal Emergency Management Agency (FEMA) as follows:

✓ **Prevention**
Prevent, avoid or stop an imminent, threatened or actual act of terrorism.

✓ **Protection**
Protect our citizens, residents, visitors and assets against the greatest threats and hazards in a manner that allows our interests, aspirations and way of life to thrive.

✓ **Mitigation**
Reduce the loss of life and property by lessening the impact of future disasters.

✓ **Response**
Respond quickly to save lives, protect property and the environment, and meet basic human needs in the aftermath of a catastrophic incident.

✓ **Recovery**
Recover through a focus on the timely restoration, strengthening and revitalization of infrastructure, housing and a sustainable economy, as well as the health, social, cultural, historic and environmental fabric of communities affected by a catastrophic incident.

All incidents, events and disasters start and end locally. If the response requires multiple assets for the mission, the local level must initiate the call for help if needed. If the local level cannot support the response and additional assistance is needed, then a request goes from the City to the County. If the County cannot fulfill the needs, the request is sent up to the State, then over to other States if it is still needed, then finally if necessary to the Federal level. The Mayor must make a Disaster Declaration, then the County Judge, next the Governor and then the President. As the requested assistance is provided, it goes in reverse order back down to the original local authority that initiated the request for help.

San Antonio Metropolitan Health District Operations Department has a section within it called **Public Health Emergency Preparedness (PHEP)**. This section is the liaison between Metro Health and the Bexar County Medical Society as well as many other organizations within Bexar County and San Antonio to include the City of San Antonio/Bexar County Emergency Operations Center. PHEP responds to all events, incidents and disasters within the city, county and region when requested. PHEP is sometimes tasked to stand up Medical Stations, Point of Distribution (POD) Sites, or other support for which they may request assistance from the Medical Reserve Corps (MRC) and/or the Bexar County Medical Society. PHEP also manages Medical Staffing contracts, Pharmacy contracts and other Emergency Response contracts as necessary to respond to the incident. PHEP works very closely with Texas Department of State Health Services (DSHS) Region 8, which is our regional State Health Department. PHEP is heavily engaged in all five missions of emergency management.

When an incident, event or call for assistance goes out, it usually starts as a phone call to the PHEP Program Manager. It can also come in the form of a text message or even an email to him. When the PHEP Program Manager is ready to initiate a response and it's approved by the Metro Health Executive Leadership Team, he activates the PHEP Team, and the Logistics Team starts moving equipment and supplies. The Medical Team starts the request for assistance from University Hospital Staff and the Medical Reserve Corps. A notice will also go to the Bexar County Medical Society as part of the Medical Volunteer Coordinating Committee team to let them know of the assistance needed from them.

Southwest Texas Regional Advisory Council (STRAC) is the regional Healthcare Coalition and the organizational leader of the Regional Medical Operation Center (RMOC) during responses. STRAC will activate the RMOC when needed to support operations, otherwise STRAC Medical Command (MEDCOMM) will coordinate smaller incidents. STRAC coordinates hospitals, Emergency Medical Services (EMS), Airlife and WebEOC communications. PHEP/Metro Health, DSHS Region 8, City of San Antonio Fire/EMS, Bexar County Emergency Services District (ESD) Fire/EMS, Private EMS, Dialysis clinics, Long Term Care and the Hospitals all work together through the RMOC during incidents and disasters when it is stood up, such as hurricanes, hospital evacuations or other significant events.

National Emergency Management and Response (National EMR), previously known as BCFS Emergency Management, is a 501(c)(3) non-governmental organization and trusted governmental partner with unparalleled resources and expertise in responding to all-hazards incidents[2]. National EMR has a contract to set up the Medical Needs Shelter when necessary, and it provides all the medical support for that Medical Shelter.

The Alamo Area **Medical Reserve Corps (MRC)** is a volunteer group of medical and nonmedical professionals. They are called upon to respond during events, incidents and disasters to work in first aid stations, medical stations within shelters and other PODs and during special events. The MRC has been instrumental in the region's success during hurricane responses for over 20 years, at First Aid Stations during Fiesta®, in Migrant Resource Center Medical Care in 2019, and throughout COVID-19 Alamodome Operations and Mobile Vaccine Operations from December 2020 through March 2022. The MRC volunteers are a national award-winning group of professionals that have continuously demonstrated great community compassion and care.

The Bexar County Medical Society (BCMS) is the organization that serves and represents the member physicians of Bexar County in providing quality healthcare for their patients and the public[3]. The BCMS has a group of professionals that support emergency preparedness and the MRC. The BCMS is also a member of the Medical Volunteer Coordinating Committee.

If you care to help, please register in the **Texas Disaster Volunteer Registry (www.texasdisastervolunteerregistry.org)** and select Bexar County, Alamo Area MRC.

References:

1. https://www.fema.gov/emergency-managers/national-preparedness/mission-core-capabilities
2. https://nationalemr.us/about-us/
3. http://bcms.org/mission.php

Bridging the Preparedness Gap Among Vulnerable Populations

By Lorenzo D. Sanchez, PhD, CEM, CBCP, Director of Emergency Management – Trinity University

Each year, the threat of hurricane season looms over Texas from June to November, bookended by severe weather seasons every spring and fall. Winter is no less challenging in south-central Texas, with its unpredictable extremes and potentially devastating community impacts, as highlighted during the Texas Winter Storm (February 2021). Throughout this statewide disaster, millions of Texans lost power, suffered with no heating, discarded spoiled food, and the list goes on, but those who were most vulnerable experienced the greatest risk to their health and safety. Despite the threat or hazard, disasters are indiscriminate and can affect our population disproportionately relative to many factors, such as socio-demographic vulnerabilities, health status, access to resources, environmental conditions, etc., among other risk indicators on the vulnerability spectrum. To better understand how to prepare our community, we must first recognize that everyone is not at equal risk to short- and long-term disaster impacts, and that preparedness is not a static construct but varies from person to household to community, and so on. Let's explore what social vulnerability to disasters means, discuss preparedness among vulnerable populations, and focus on community resources to bridge the preparedness gap.

History provides us with many examples of social crises resulting from catastrophe – Hurricane Katrina (2005) topping the list as one of the most devastating natural disasters in U.S. history. During Katrina, critical conditions resulted in strained social services, stressed healthcare systems, and devastating regional impacts due to deteriorated environmental conditions and residual effects throughout the recovery process. From a broader perspective, these types of issues expose social vulnerability within our communities, which is generally described as a state of susceptibility to harm from the stresses associated with exposure to detrimental effects of both environmental and social change relative to one's ability to adapt and cope as a means of resiliency[1,2]. Another significant aspect of social vulnerability involves health status related to pre-existing medical conditions that can become aggravated by an already bad situation; those in poor health due to acute and chronic conditions, comorbidities, etc., may display signs of distress more quickly that lead to deteriorated health status (or worse) if not properly prepared[3].

Other risks to health and safety include extreme environmental conditions, physical and emotional trauma, and reduced access to medications and healthcare systems, among other factors[4]. After a hurricane for example, healthcare systems can quickly reach emergency surge capacity, but persons with pre-existing medical conditions may also seek care due in part to a lack of personal preparedness, awareness or access to adequate resources to meet their specific needs[3]. This was made apparent during a study of medications distributed at hurricane evacuation centers in San Antonio, Texas, post-Hurricane Katrina, highlighting low preparedness among medically sensitive populations as evidenced by the type and volume of medications distributed by disaster medical assessment teams (DMAT) to evacuees[4]. The most commonly distributed medications were for cardiovascular diseases (39%), indicating that those with this chronic condition may have special disaster preparedness considerations that were not previously addressed[4]. This was just one example, and other socially vulnerable populations at-risk may include persons with functional limitations or disabilities, older adults (and the very young), marginalized persons, quartered populations, persons requiring dependent care and individuals who lack regular access to healthcare services[5].

At-risk individuals and households are encouraged to appropriately prepare for disasters in order to address their current and unmet needs for self-sufficiency in the event healthcare systems, response agencies and social services are compromised or inundated with requests for assistance[3]. However, the needs and requirements of those most vulnerable may differ substantially in terms of the resources necessary to be prepared given their specific needs, as well as their ability to accomplish these personal and household safety actions prior to disaster. Since disasters impact communities through the disruption of essential social services, overwhelmed healthcare systems, and depletion of regional medical resources, personal preparation is critical to increase disaster resiliency.

So far, this article has illustrated that preparedness isn't a "one size fits all" approach; rather, those exhibiting forms of social vulnerability may have special considerations for emergency preparation. In general, there are three key preparedness principles that can increase disaster resiliency within our community, as well as for the most vulnerable:

1. Make a Plan: More broadly, create a personal and family emergency plan to address what to do before, during and after a disaster, as well as have a communications strategy with important numbers for family members and social services. Special considerations should be made for known health and medical conditions, such as contact information for healthcare providers, actions steps for those with disabilities or functional needs, and where to go if emergency sheltering is necessary including those that can accommodate special needs. Also, practice this plan regularly for awareness and to identify any planning gaps, then incorporate lessons learned.

2. Make a Go-Kit: Everyone is encouraged to have an emergency "go-kit" with all the essentials, including non-perishable food items, water (1 gallon per person, per day), first aid, hygiene supplies, communication devices, pet supplies, important documents and items for evacuating by car. Persons with medical conditions or specific vulnerabilities are encouraged to have a small cache of medication for emergency use, durable medical equipment, blankets, box fans/cooling devices and heaters and other key items relative to their specific conditions. If electrically dependent for home healthcare needs, a small portable generator should be considered as well as knowing an alternative location to receive emergency power, clean water and related resources.

3. Stay Informed: Know how to get information during a disaster. Registering for local weather alerts, as well as downloading news and other apps help to receive protective actions and stay in the know. Some of the most vulnerable, especially the elderly, may not have access to reliable or current technologies, so caregivers, neighbors and healthcare providers serve as a critical link – be sure to check on the vulnerable.

Resources available to link vulnerable populations with services, support and resources:

- Texas Ready Website: The Texas Department of Health & Human Services maintains the Texas Ready website that promotes disaster planning tools, checklists, tips and preparedness videos (www.texasready.gov)
- Bexar County Behavioral Health Resource Directory: Bexar County maintains a resource directory of services related to mental health, substance use, emergency shelters/housing, social services, specialized services and additional local and state resources (www.bexar.org/documentcenter/view/29123/behavioral-health-resource-directory?bidId=)
- The State of Texas Emergency Assistance Registry (STEAR): STEAR is a free public registry to link local emergency planners and first responders with persons who have medical or functional needs, or those requiring additional medical assistance during an emergency event (www.tdem.texas.gov/response/state-of-texas-emergency-assistance-registry)
- Other Resources: 2-1-1 Texas – statewide health and social services (www.211texas.org), 3-1-1 San Antonio – City resources and support (www.311.sanantonio.gov), DeafLink – accessible critical communications (www.deaflink.com), San Antonio & National Volunteer Organizations Active in Disasters (VOAD) (www.nvoad.org)

Community resiliency to disasters is founded on preparing everyone with the tools, resources and plans necessary to mitigate risk, with particular focus on preparedness among the most vulnerable. Caregivers, medical professionals, community advocates, emergency managers and officials are encouraged to support, assist and educate vulnerable populations on disaster preparedness, as well as connect them with appropriate resources to meet their unmet needs. Together, we can bridge the preparedness gap!

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Medical Practice Disaster Contingency Planning:

Not Just Good Sense … It's The Law

By Ann Nurre, CISSP and David Alex Schulz, CIPP

Contingency planning is often overlooked in medical practices, understandably when daily patient and administrative needs eclipse all else on a punch list. But life happens and Texas is prone to natural disasters; the pandemic taught us the ramifications of being caught unaware by catastrophic events. Here in Bexar County, where water and ice wreak havoc on our infrastructure, medical practices cannot afford to overlook the HIPAA requirements for Contingency Planning.

Laid out in the HIPAA Security Rule {CFR 164.308 (a) (7) (i)}, preparedness is classed as an administrative safeguard to protect the availability and confidentiality of electronic patient health information, as well as securing essential business documentation. Some of the specifications are required and some are addressable.

Caution: Addressable is not synonymous with optional – it requires that instead of following prescriptive specifications of a "one size fits all" policy, the covered entity must determine how to achieve the goals in a manner most appropriate to the practice – and document each step, maintaining detailed records.

Let's look at what all of this actually means.

There are five administrative safeguards in the HIPAA regulations dealing with Contingency Planning. They are:

HIPAA Reference	Standard	Implementation
164.308(a)(7)(ii)(A)	Data Backup Plan	**Required**
164.308(a)(7)(ii)(B)	Disaster Recovery Plan	**Required**
164.308(a)(7)(ii)(C)	Emergency Mode Operation Plan	**Required**
164.308(a)(7)(ii)(D)	Testing and Revision Procedures	Addressable
164.308(a)(7)(ii)(E)	Applications and Data Criticality Analysis	Addressable

Data Backup Plan (Required)

The requirement is to have an up-to-date backup of all essential patient and administrative data. The recommendation is to have two copies on-site (if the practice's IT functions are locally managed on premises) and one copy stored off-site. This may be extreme for a small practice but having at least one current backup is essential.

Handing the responsibility to a third-party vendor, if your practice ePHI software is hosted by a Managed Service Provider (MSP), provides no relief of compliance. The data owner – the practice – must have assurance that the MSP is performing backups.

Any requirements regarding HIPAA compliance should be communicated to the MSP and written into the contract. Failure to have an effective Business Associate Agreement will massively complicate any data breach issues suffered by the Service Provider. Make sure to carefully review your contract with the MSP, and ensure your practice is being notified of any substantive changes in their policies.

Disaster Recovery Plan (Required)

The requirement is to establish (and implement as needed) procedures to restore any loss of data. Think of the steps that go into a school's fire drill as an example of the process and punch list. While you already know that a backup of data exists, is there a process for re-accessing and re-populating your data?

Copies of the data restoration procedures must be readily accessible at more than one location and should not rely on the availability of local power or network. Backup procedures must include steps to ensure that all protections (patches, configurations, permissions, firewalls, etc.) are re-applied and restored before ePHI is restored to a system. Work with your IT manager or MSP to create procedures to restore loss of ePHI in a disaster or emergency – and then drill them annually.

Emergency Mode Operation Plan (Required)

Should you suffer an egregious data loss in an emergency, these are the questions the practice will be facing:

- Have you ensured that your emergency operations procedures maintain security protections for ePHI?
- Have you evaluated your operations in emergency mode, for example in a technical breakdown or grid failure, whether your electronic data is still adequately secure?
- Have you documented the assessment, its conclusions and implemented steps for improvement?

There are prescribed regulations governing evacuations, both before and after a crisis occurs: HIPAA entities' emergency response plans must include logging out of systems that contain ePHI, securing files and locking up before evacuating a building, if safe to do so; HIPAA entities should have processes to ensure there was no breach when the area is re-occupied.

Testing and Revision Procedures (Addressable)

This provides a great example of "how to address the addressable" – in short, what HHS looks for afterward depends on the practice's size, IT operations and locations.

Begin by gathering the ePHI and physical plant stakeholders (partners, office manager, IT managers, building security and maintenance management, etc.).

Conduct a table-top exercise, walking through what each division's responsibility might be in varying crises, drawing on the decades' disasters. FEMA, TAMU and others maintain detailed, localized disaster and recovery records. Develop a general process, and then particularize for floods, freeze-outs, fires and blackouts. Develop an annual live-fire drill in consort with the IT manager. Running drills is critical, as well as documenting results and lessons learned. Practice makes perfect, and investigators look for a commitment to due diligence.

Applications and Data Criticality Analysis (Addressable)

The purpose of the Application & Data Criticality Analysis is to determine how crucial each software component is to the practice and the potential losses which may be incurred if these components were not available for a period of time. Your IT manager or MSP ought to be delighted that you're interested. Sit with them (as might have been done in the table-top exercise, above) and review specific software, revision levels, patches and document the results and any changes going forward.

A Final Note on Neglecting Drills: The Titanic conducted no lifeboat or fire drills since departing Southampton. A lifeboat drill had been scheduled for the morning before the ship sank but was cancelled because the ship's captain wanted to deliver one last Sunday service before he went into full retirement.

Ann Nurre and David Schulz are founding partners of Cyber Risk Associates of San Antonio, devoted to the privacy and security of information.

Disaster Response: How Physicians Can Serve the Bexar County and Texas Community

By George-Thomas Pugh, MD

Disasters can strike at any time and place, affecting the health and well-being of individuals and communities. Whether it is a pandemic, a hurricane, a flood, a fire or a terrorist attack, disasters pose significant challenges to the healthcare system. As physicians, we have a unique opportunity and responsibility to serve our community in times of disasters. In this article, we will explore some of the ways that physicians can get involved in disaster response in Bexar County, Texas, at the local and state levels.

Local Level:
Bexar County Office of Emergency Management

One of the first steps to getting involved in disaster response is to be familiar with the local emergency management plans and resources in our area. Bexar County has an Office of Emergency Management (OEM) that coordinates the county's efforts to prepare for, prevent, plan for, respond to and recover from all-hazard events. The OEM works closely with local jurisdictions, state agencies, federal partners, volunteer organizations and the private sector to develop and maintain a comprehensive emergency management plan and a regional homeland security strategy. The OEM also provides numerous services and programs to enhance the community's readiness and resilience. We can stay connected with the OEM and get the latest news and information through their website (https://www.bexar.org/674/Office-of-Emergency-Management), Facebook (https://www.facebook.com/BexarCountyOEM), and Twitter (https://twitter.com/BexarCountyOEM) accounts. You can also sign up for emergency notifications through their website or by texting BEXARCOUNTY to 888777.

Community Emergency Response Team

Another way to get involved in disaster response at the local level is to join the Community Emergency Response Team (CERT) program. CERT is a national program that trains volunteers to assist their communities in a disaster when professional responders are overwhelmed or delayed. CERT volunteers learn basic disaster response skills such as fire safety, light search and rescue, team organization, disaster medical operations, terrorism awareness and more. As physicians, we can use our medical knowledge and skills to enhance the CERT capabilities and provide lifesaving care to our neighbors. To join CERT, a training course must be completed that is offered by the OEM or other local agencies. More information about CERT and upcoming training opportunities can be found on their website (https://www.bexar.org/700/Volunteering).

Southwest Texas Regional Advisory Council

A third way to get involved in disaster response at the local level is to collaborate with the Southwest Texas Regional Advisory Council (STRAC), which is designated by the Texas Department of State Health Services (DSHS) to develop, implement and maintain the regional trauma and emergency healthcare system for the 22 counties in Trauma Service Area - P (TSA-P). STRAC provides a platform for members of the emergency healthcare system to communicate, enhance networking and coordinate patient care issues as it relates to the transport and treatment of time dependent pathologies. STRAC also hosts a regional emergency healthcare systems conference that delivers continuing education for physicians, nurses and EMS as well as an opportunity to meet with leaders in the medical industry, learn about emerging products, and work through system processes.

a. Emergency Medical Task Force

As physicians, we can participate in STRAC's programs such as trauma, hospital preparedness, acute care research, education, data analysis, quality improvement, injury prevention, mass casualty planning, etc. We can also join the local STRAC Region 8's Emergency Medical Task Force (EMTF), which is part of a statewide program that provides a well-coordinated response, offering rapid professional medical assistance to emergency operation systems during large-scale incidents. The EMTF consists of several components such as ambulance strike teams (AST), mobile medical units (MMU), registered nurse strike teams (RNST), medical incident support teams (MIST) and ambulance staging managers (ASM). As physicians, we can support the EMTF by providing medical direction or supervision for these components or by serving as members of these teams when deployed. More information about STRAC and EMTF can be found on their websites (https://strac.org/ and https://www.strac.org/emtf8).

Emergency Management Committee

Another way to get involved in disaster planning and response is to participate in their respective hospital's Emergency Management Committee. Emergency Management Committees are multidiscipli-

nary groups that are responsible for planning, organizing, training, equipping, exercising, evaluating and taking corrective action to ensure effective coordination during incident response. These committees are required by the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission to comply with their emergency preparedness standards. Physicians can get involved in these committees by volunteering their expertise, participating in drills and exercises, providing feedback and suggestions, and serving as leaders or liaisons in the incident command system. By joining these committees, physicians can contribute to the safety and quality of care for patients and staff during emergencies. Physicians from all specialties and backgrounds should participate in these committees because a diverse group is vital to ensure that policies created in these committees reflect the needs of the entire hospital and every service line.

Bexar County Medical Society Emergency Preparedness Committee

Finally, the easiest way to become involved in emergency preparedness is through the BCMS Emergency Preparedness Committee. This committee coordinates physician participation with the other San Antonio medical and emergency organizations mentioned above. They also develop processes to assist physicians in preparing for significant but unexpected emergency situations affecting the community.

The focus of the committee for the last several years has been on organizational efforts to prepare for hurricane evacuations to Bexar County from Texas coastal areas. The committee has also worked to create detailed information for physician offices preparing for pandemic flu and a variety of terrorist scenarios. The committee provides a ready source of information for physician offices to rapidly assimilate in order to make decisions about how or if to participate in various disaster/terrorist situations when the time comes.

To join the BCMS Emergency Preparedness Committee, go to http://bcms.org/EmergPrep.php.

State Level: Texas Disaster Volunteer Registry

At the state level, there are also several opportunities for physicians to get involved in disaster response. One of them is to sign up with the Texas Disaster Volunteer Registry (TDVR), which is run by the DSHS. The TDVR is a web-based system that matches volunteers with local needs during or after a disaster. Texas physicians can sign up with the registry as volunteers to provide medical help to Texas communities in need. The TDVR allows physicians to indicate availability, location preferences, skills, credentials and affiliations. The TDVR also verifies our licenses and credentials so that we can be deployed quickly when needed. To sign up with the TDVR, one must create an account on their website (https://www.texasdisastervolunteerregistry.org/) and complete a profile.

Texas Division of Emergency Management

Another way to get involved in disaster response at the state level is to collaborate with the Texas Division of Emergency Management (TDEM), which is responsible for coordinating the state's overall emergency preparedness, response, recovery and mitigation efforts. Just as the BCOEM functions at a local/county level, the TDEM on a state level works closely with local jurisdictions, state agencies, federal partners, volunteer organizations and the private sector to develop and maintain a statewide emergency management plan and a statewide homeland security strategy. TDEM also administers various grants and programs to enhance the state's capabilities and capacities to prevent, protect against, respond to, recover from and mitigate all hazards. As physicians, we can participate in TDEM's activities such as training, exercises, planning, research, data analysis, public education, etc. TDEM also has resources that can be accessed such as emergency notifications, situation reports, disaster declarations, maps, data portals, etc. Additionally, the TDEM hosts an annual conference. The conference attracts over 3,000 elected officials, first responders, emergency managers and decision makers from across Texas. The conference provides jurisdictions and individuals an opportunity to learn about innovative products and services from numerous organizations. More information about TDEM can be found on their website (https://www.tdem.texas.gov/).

As physicians, we have the unique opportunity and responsibility to serve our community in times of disaster. By getting involved in disaster response at the local and state level, we can make a difference in saving lives, reducing suffering and improving recovery. As outlined above, there are many ways that we can contribute our skills and expertise to the emergency healthcare system. I encourage you to explore these options and find the one that suits your interests and availability. Together, we can make Texas and Bexar County stronger and more resilient in the face of any disaster.

Dr. George-Thomas Pugh, MD is an emergency medicine physician and is fellowship trained in disaster medicine. He works for Greater San Antonio Emergency Physicians and serves as their disaster services director. He is also active with the American College of Emergency Medicine (ACEP) Disaster Medicine Section, and currently serves as their section councilor as well as the current lead of the newly formed Disaster Medicine Section mentorship committee. Dr. Pugh is a member of the Bexar County Medical Society.

University Hospital and the new University Health Women's and Children's Hospital at the University Health Main Campus serve South Texas with a Level I trauma center for adults and children.

Preventing Firearm-Related Death, Injury and Disability Demands Cooperation, Communication and Consensus

By Ronald M. Stewart, MD

I've lost count of the number of times reporters and others have asked me how it feels to care for victims of a mass shooting. That's because we have treated adults and children with horrific wounds caused by AR-15-styled firearms from two of the largest mass shootings in modern U.S. History, the Robb Elementary School shooting on May 24, 2022, and the Sutherland Springs First Baptist Church shooting on November 5, 2017. If it can happen in Uvalde and Sutherland Springs, this type of shooting can happen anywhere.

Responding to these tragedies takes a toll on healthcare professionals—but it's nowhere close to the toll it takes on their patients, their families and their loved ones, and the loved ones of those who never made it to the trauma center.

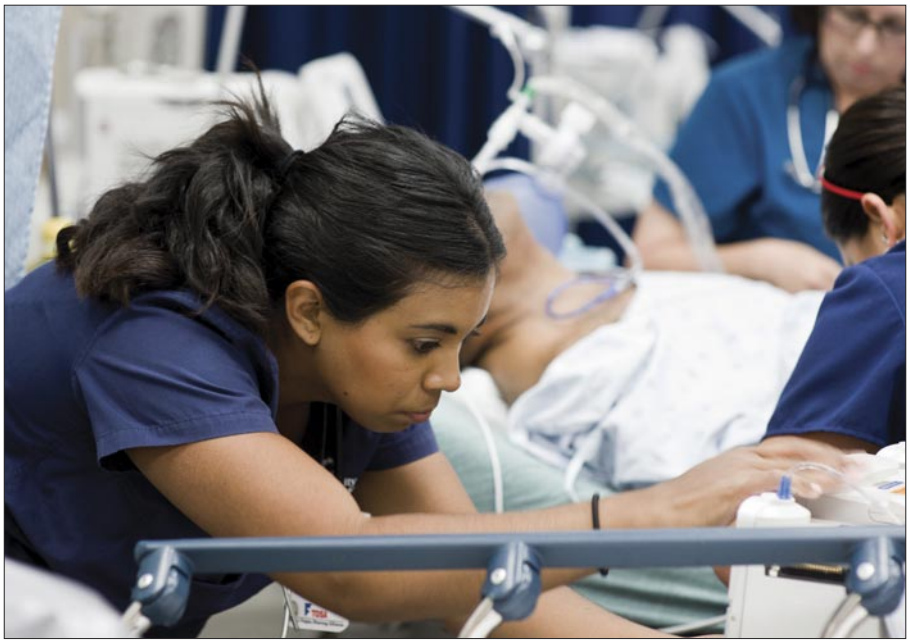
Our focus must be on doing the right thing for those innocent victims, and we must focus on preventing other children and families from experiencing this unfathomable suffering.

I have been doing this work for almost 40 years. It is not the late nights or the fatigue of this high-intensity work that weighs on me the most. The greatest toll on me and my team members comes from witnessing the horrific injuries we saw in these tragedies, and from the incredibly hard and heartbreaking conversations we had to have with the parents and families of these innocent victims, and the similar conversations we have with patients almost every single day in our trauma center.

To me, the toll is worse because these tragedies are preventable.

All of us are collectively responsible for the culture of violence and for choosing not to come together across ridiculous, man-made divi-

sions in a way that could effectively put an end to this violence. Freedom demands responsibility. The wave of intentional injury and mass shootings is not the cost of freedom. It is the cost of irresponsibility and indifference to the suffering of our children.



As predicted, 2020 was the year that firearm injuries became the leading cause of death among U.S. children and adolescents (ages 1-19). Not the leading cause of traumatic death, but the leading cause of death—all deaths. The magnitude of the deaths in our children was and is much greater than the SARS-Co-V2 pandemic, and the magnitude of the impact on our health is far greater than the deaths alone. Intentional injury often leads to psychological injury, which predisposes children to a lifetime of increased health risks, including future physical injury, mental health conditions (anxiety, depression, PTSD), chronic medical conditions (obesity, diabetes, lung disease, heart disease, poor maternal outcomes including fetal death, and increased rates of smoking and substance use). The financial cost of intentional injury and the sequelae that follow are conservatively in excess of a trillion dollars in the United States. The extreme harm and cost to our patients, our communities and our families demand healthcare professionals' action, and it demands our advocacy.

Advocacy does not require a restriction of freedom, and it does not infringe on Second Amendment rights. But it does require setting aside partisan politics for the sake of our children and grandchildren. And our children's future is literally at stake. In healthcare, cooperation and communication save lives. In order to prevent firearm-related injuries, we have to move from debate and argument to cooperation and communication. This does not require a significant compromise between people who may disagree about guns, but it does require changing the conversation. For those who are skeptical this can be done, it has been done in the trauma and emergency healthcare community.

A lot of groundwork has been completed. As part of its firearm injury prevention effort, the American College of Surgeons Committee on Trauma established the Firearm Strategy Team (FAST) in 2017 and the Improving Social Determinants to Attenuate Violence (ISAVE) workgroup in 2018. The FAST workgroup included trauma surgeons, paramedics and emergency physicians from across the country, many of whom are avid firearm owners. The ISAVE workgroup included violence prevention professionals from across the United States.

The FAST workgroup provided consensus recommendations grounded in the reality that firearm ownership is a constitutionally protected right and that we also have an epidemic of violence and firearm-related injury, death and disability. The FAST workgroup made relevant, nuanced and expert recommendations directed toward reducing firearm-related death and disability. The FAST members agreed that we can address this epidemic of violence by committing to work together to understand and address the root causes of violence while simultaneously making firearm ownership as safe as reasonably possible for those who own firearms and those who do not.

This work proved that people with significantly differing views on firearms can and will enthusiastically work together to reduce unnecessary death and suffering from firearm-related injury and intentional violence.

The ISAVE workgroup made four broad recommendations: 1) Implement trauma-informed care in all trauma centers and health systems, 2) Implement hospital and community-based violence prevention and intervention programs, 3) Secure health system partnership and investment into marginalized and at-risk communities, 4) Procure healthcare systems and healthcare professionals' advocacy for these recommendations.

Based on these workgroups' recommendations, two separate healthcare summits were hosted, which included representation of almost every major healthcare professional organization in the U.S. These 47 major professional organizations provided supporting recommendations for how healthcare professionals could continue to collaborate to reduce firearm-related injury death and disability.

Following the Robb Elementary School Shooting in Uvalde, with the leadership of Senators Cornyn (R-Texas) and Murphy (D-Connecticut), Congress passed the Bipartisan Safer Communities Act last summer. This is an important first step toward a healthier future, but more is needed to prevent the horrific mass shootings similar to Uvalde and Sutherland Springs.

continued on page 24

continued from page 23

I will end by paraphrasing the closing quote from the FAST workgroup authors. We know there will be people who think we did not go far enough and also people who think we went too far, but we believe the middle ground moves the purpose forward. We know thousands of American lives can be saved each year. Full implementation of the measures we call for would preserve freedom and simultaneously make our country safer, stronger and healthier, and we have to do it together, there is no other way.

For more information, visit www.facs.org/quality-programs/trauma/advocacy-and-injury-prevention/firearm-injury-prevention-activities/.

At University Hospital's Level I trauma center, multispecialty teams are available around the clock to respond to the most critically injured adults and children.

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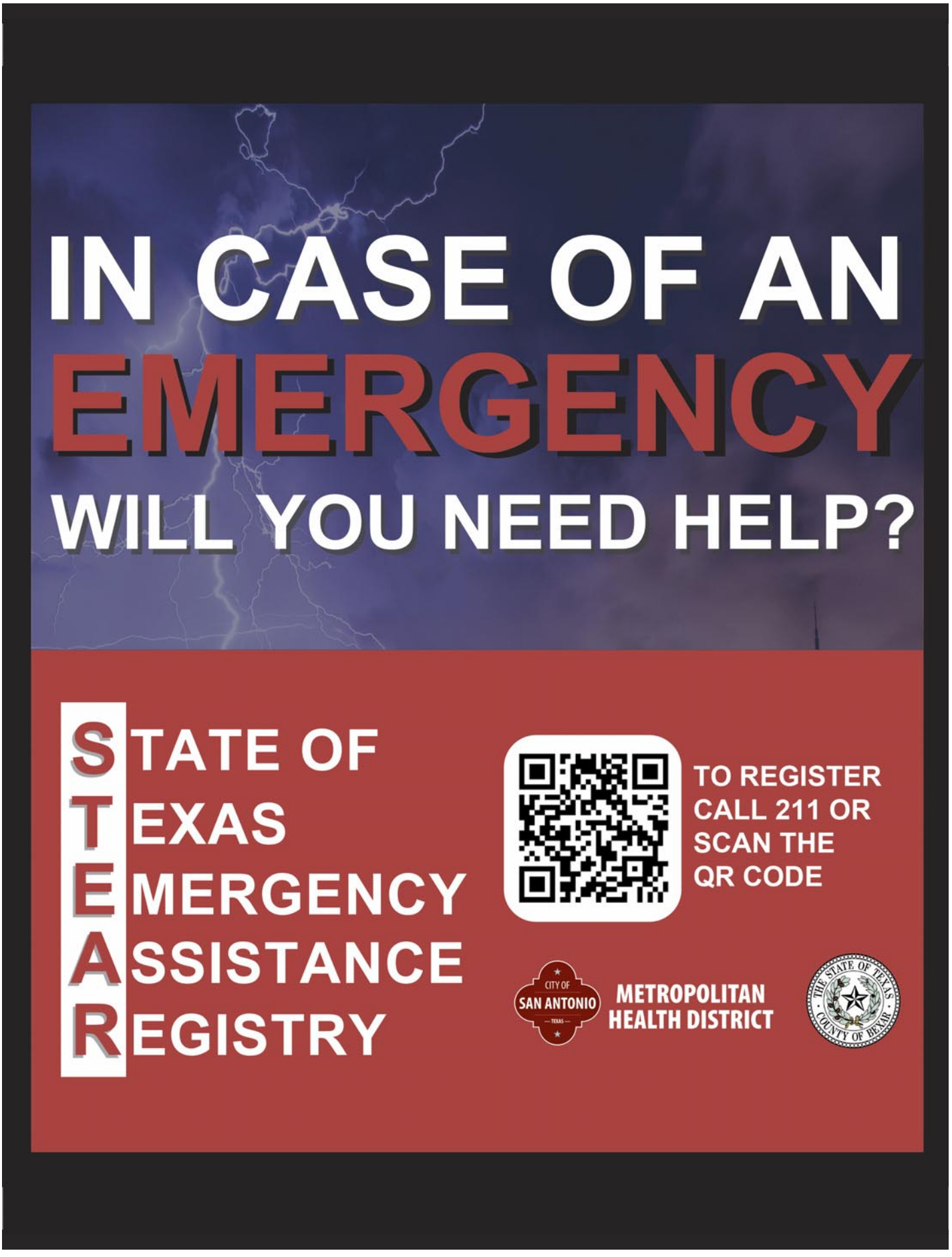
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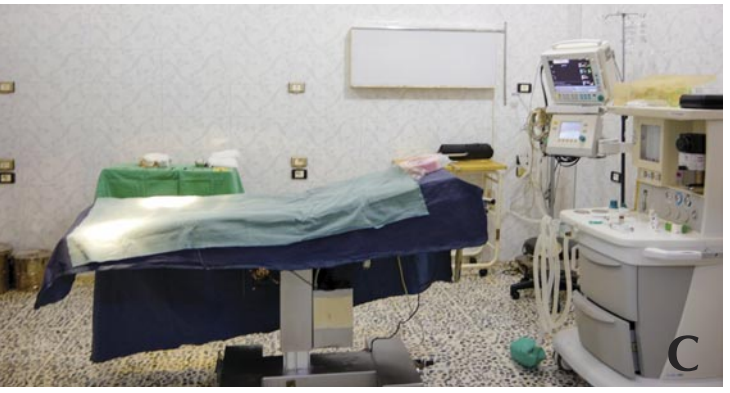
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Hope and Healing in Aqrabat

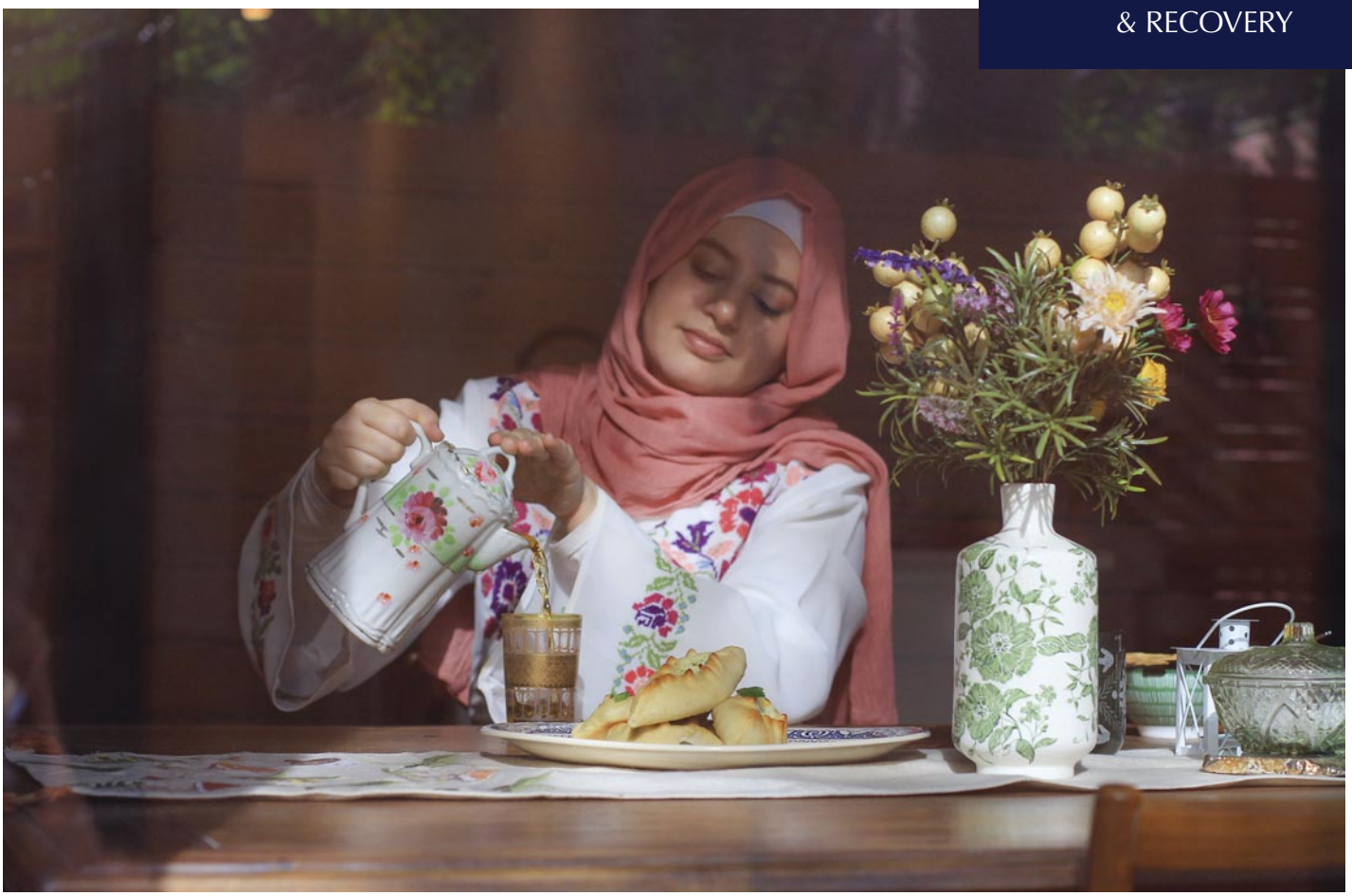
By Salma Yazji, MD

On February 6, 2023, a 7.8 magnitude earthquake and multiple aftershocks devastated the region of central and southern Turkey and northwest Syria, causing extensive destruction and tens of thousands of fatalities (Photograph A). Union of Medical Care and Relief Organizations International (UOSSM) is one of the organizations that joined the rescue effort to deliver care in northern Syria. UOSSM was founded in 2012 in France and is a non-governmental coalition of humanitarian and medical organizations from the United States, Canada, France, United Kingdom, Switzerland and Turkey that provides humanitarian and medical assistance in areas of crisis. My father, Dr. Monzer Yazji, is a co-founder of UOSSM and has served on its board since 2012. He is the vice-president of UOSSM USA. I was honored to travel to Syria in March of this year to participate in the healing work of UOSSM and document their humanitarian effort through photographs.

Housed in what was once a police station building, Aqrabat Hospital is located among the olive trees in Idlib, Syria. As the only hospital in the region offering reconstructive surgeries and rehabilitation, the area's earthquakes filled the hospital's beds with newly orphaned children with debilitating injuries, such as amputated limbs. Noor, a toddler now missing her parents and her left leg after being rescued from rubble, is surrounded by a powerful community of healing (Photograph B). The life shattering earthquakes left many Syrian children without parents, limbs and homes (Photograph C). Aqrabat Hospital provides patients and many others hope, healing and support. As the only orthopedic reconstructive surgeon in all of Northwest Syria, Dr. Qadur conducted hundreds of surgeries a day following the earthquake disasters. His operating room sits in the basement of Aqrabat Hospital and is run by the most compassionate team of individuals (Photograph D).

To learn more about the work of UOSSM, visit: www.uossm.org.

Salma Yazji, MD, Class of 2023, Long School of Medicine, UT Health San Antonio, will begin her residency in Psychiatry at the University of Colorado, Anschutz School of Medicine in July 2023.



the taste of resilience

By Salma Yazji, MD

i stand in my kitchen
its marble counters dusted with flour,
the walls soaking in the sun's golden hue,
a jar of olives tucked away into the corner,
picked by callused hands in the homeland
and carried over a thousand miles
in my grandfather's check-in bag
(it smells of cardamom, sumac, soil, coffee grounds).

i think of the kitchens in Syria
now buried under rubble,
their countertops dissolved into dust,
their walls never to taste sunlight again,
their jars of olives crushed into infinite fragments, the oils seeping into the colorless ground below.

i feel like a thief
greedily cooking the dishes taught to me by those who
no longer have a kitchen to cook in.

i grieve
i forget
i grieve
i forget.

sometimes
i think the earth is testing us.
how hard must it shake
to catch our attentions?
to have Syria be remembered
for just a few more hours,
for just a few more days.

Syria,
i dream of the day i stand in your kitchens again,
enveloped by the smells i now only get wisps of
from check-in bags
and momentary trays in the oven.

Syria,
i'm grieving you.

Syria,
i'm forgetting you.

but *Syria,*
when i cook,
i remember you.

Uvalde Shooting Survivor Meets Blood Donors Who Saved Her Life

Meeting also marks South Texas Blood & Tissue's fifth anniversary of program designed to boost trauma survival

By Laurryn Salem

A 10-year-old survivor of the Uvalde school shooting thanked her life-savers – her blood donors. The meeting also highlights a major milestone for South Texas Blood & Tissue's lifesaving whole-blood donor program.

'Forever grateful'

Christina and Ruben Zamora have met and thanked emergency medical technicians to trauma surgeons involved in the care of their daughter Mayah, who was injured in the shooting at Robb Elementary School in May 2022.

But Saturday, January 28, was the first time they met those whose blood donations were used in Mayah's emergency treatment. "We're forever grateful to the people who saved my life, and I hope my story will let people know how important donating blood is to saving lives," said Mayah.

Among the donors was 17-year-old Adrianna Garcia, who donated for the first time at a drive at Poteet High School. Mayah and her family also met donors Larry Whatley, who has been giving blood since 1976, and Sylvia Enriquez.

"A blood donation is usually a gift to someone you will never meet or never know," said Adrienne Mendoza, Chief Operating Officer, South Texas Blood & Tissue. "Today we have that great and unique honor of making that connection."

Making a difference

On the day of the Uvalde tragedy, South Texas Blood & Tissue had specially screened blood from its Heroes in Arms program ready for use by emergency responders. As soon as the organization was alerted to the need, this lifesaving resource was provided to air medical helicopters to be used at the scene.

Mayah received an emergency blood transfusion while in transport to the hospital. She also received O-negative blood, which is given in

This page, top left: Mayah Zamora meets one of her blood donors, 17-year-old Adrianna Garcia.
Bottom left: Dr. Ronald M. Stewart (right), a surgeon at University Hospital's Level I trauma center and Chair of the Department of Surgery at UT Health San Antonio, and blood donor, Adrianna Garcia.
Top right: Christina and Ruben Zamora advocate for blood donation, sharing how it saved their daughter Mayah's life.

many cases to pediatric patients.

"What we're seeing here today is living proof that this program makes a difference," said Dr. Ronald M. Stewart, a surgeon at University Hospital's Level I trauma center and Chair of the Department of Surgery at UT Health San Antonio.

Encouraging blood donations

Stewart told Mayah's parents that she survived the helicopter trip to University Hospital's Trauma Center because of blood transfusions. As a result, they have become strong advocates for blood donation. "You've got to make something good out of something so bad," Christina Zamora said. "This is something that is part of the good that she can do."

Ruben Zamora encouraged people across South Texas to donate. "I'm going to be the second one in my family to give blood, and I'm terrified, but Mayah said she would hold my hand," he said.

Realizing the need

Mendoza highlighted the need for blood at all times. "Mayah's story, for us, is a powerful symbol of the need for all kinds of donors and the need for donors to continue to give blood. We hope people realize the need," she said. "It was the blood given by generous donors in the days ahead of Uvalde that was ready for Mayah that tragic day. By becoming a regular blood donor and giving four times a year, you'll help our community be ready at any time for any tragedy or need."

To learn more about the Heroes in Arms Program, visit www.bio-bridgeglobal.org/donors/blood-donation/heroes-in-arms.

Are you an O-positive donor who'd like to join Heroes in Arms? Contact us today at 210-731-5590 to find out if you are eligible.

Laurryn Salem is a Multimedia Communications Specialist for BioBridge Global and its subsidiaries, including South Texas Blood & Tissue. Prior to joining the organization in November 2021, she was a local newspaper reporter in Columbia, South Carolina.

A Primary Care Physician's Role in Combating Declining Pediatric Vaccination Rates

By Corynne McEachern, BS, Morgan Lockwood, BS, MA and Madisyn Moak, BS

In 2019 the World Health Organization (WHO) labeled vaccine hesitancy as one of the top 10 threats to global health. WHO defined vaccine hesitancy as, "the reluctance or refusal to vaccinate despite the availability of vaccines"[1]. Since the COVID-19 pandemic, vaccination rates among children have decreased even more. The American Academy of Family Physicians released an article breaking down the CDC's Morbidity and Mortality Weekly Report published on January 13, 2023, which stated that the rate of children who have received two doses of the MMR vaccine as well as state-required doses of the polio, varicella and DTap vaccines was only 93% for the 2021-22 school year. This was a 1% decrease from the previous year. Before the pandemic, the vaccination rates were even higher, at 95% for the 2019-20 school year[2].

Various studies have been conducted to try and understand the reasons why more and more parents are choosing not to vaccinate their children. One such study titled "Vaccine Hesitancy in Pediatrics" concluded that both psychological and demographic factors such as age, gender, ethnicity, level of education and

income contribute to a parent's decision to not vaccinate their children. The authors of the article, Dr. Lafnitzegger and Dr. Gaviria-Agudelo, found that the factors that influence a parent's decision to vaccinate include their values and past experiences, internet and social media, confidence in science, social responsibilities, as well as spiritual and political factors. One specific reason why some parents have chosen not to vaccinate is that they do not see the necessity of a vaccine for diseases now considered "rare"[3]. Consequently, vaccine-preventable diseases, such as measles, have started to rise. In fact, measles has increased by 30% globally[1] and there have been outbreaks of other vaccine-preventable diseases such as mumps, rubella and pertussis associated with under-vaccinated communities [4].

A way to address parents who are vaccine-hesitant is via open communication and education from their child's pediatric provider. In "Parents With Doubts About Vaccines: Which Vaccines and Reasons Why," parents who were originally vaccine-hesitant who later opted for their child to receive the vaccine, listed "information or assurances from healthcare provider" as the main reason they changed their decision[5]. This highlights the importance of having a strong physician-parent relationship as it allows physicians the opportunity to address parents' concerns in a respectful manner and neutralize any negative ideas or misinformation regarding immunization efforts. On the contrary, when parents feel that their child's provider is not approachable, they believe that they do not have access to adequate information about immunizations. Therefore, it should be a high priority for national, state and local immunization programs to provide educational materials to medical professionals who can then provide it to vaccine-hesitant parents to further enhance communication efforts.

The fact remains, less children are being vaccinated today than before the pandemic. It falls on the healthcare provider to be a trusted voice of reason when parents express concern about vaccinating their children. Parents currently have access to countless opinions and "facts" about vaccines at their fingertips. Despite this, a majority of parents still believe that physicians are a more reliable source than the information found on the internet[4]. When asked, 40% of parents said that they did not completely understand how vaccines worked. After being counseled by their provider, this number dropped to only 14%[6]. It is therefore important to help guide parents and provide credible information so that they can make informed decisions about their child's health. Some strategies that have been proven to be helpful in establishing vaccine confidence include starting education early, being honest about side effects, and addressing pain[4]. Primary care physicians should take these strategies into account when discussing routine vaccinations with parents in an effort to stop the decline in vaccination rates and protect children against vaccine-preventable diseases.

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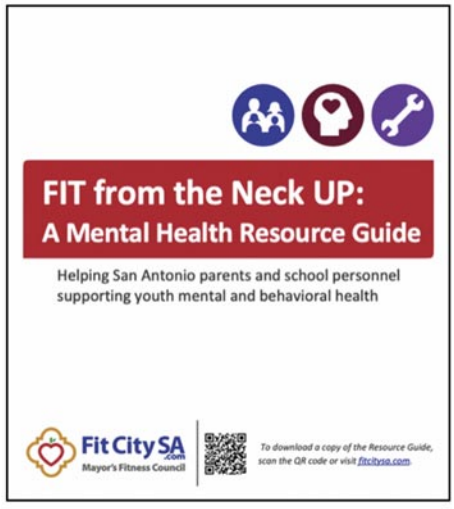
Youth Mental Health and Suicide Prevention

By Mrudula Rao, MD and Maggie G. Mortali, MPH

Mental health is an essential part of overall health. Youth with mental health conditions may experience challenges at home, school, community and with interpersonal relationships. In the United States, 42% of high school students report experiencing persistent feelings of sadness or hopelessness in the past year, and that they were unable to participate in their regular activities. This is a 50% increase between 2011 and 2021 (28% to 42%)[1].

Poor mental health can result in serious negative outcomes for the health and development of youth and young adults, which can last into adulthood[1]. Youth who experience poor mental health do worse academically and may experience physical health problems. Suicide risk, including suicide ideation, plans and attempts, puts young people at risk and is a marker for experience with trauma and other mental health issues[1].

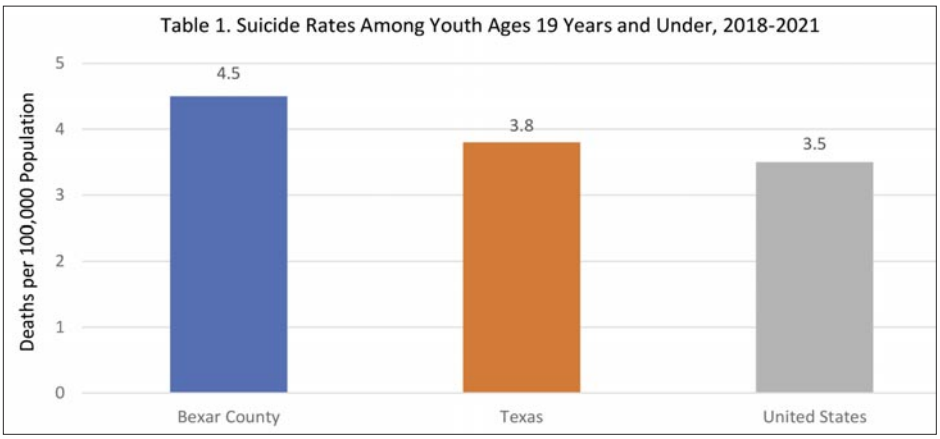
One in five children and adolescents aged 3 to 17 years in the United States report having mental, emotional, developmental or behavioral disorders[2]. Treatment rates vary and more is needed to provide adequate care and treatment options in every community[2]. The U.S. Surgeon General declared a state of emergency related to youth mental health, and issued an advisory calling for a unified national response to the mental health challenges young people are facing[3]. This further underscores the need for action to help stem the long-term impacts of the pandemic on the mental health and well-being of children and adolescents.

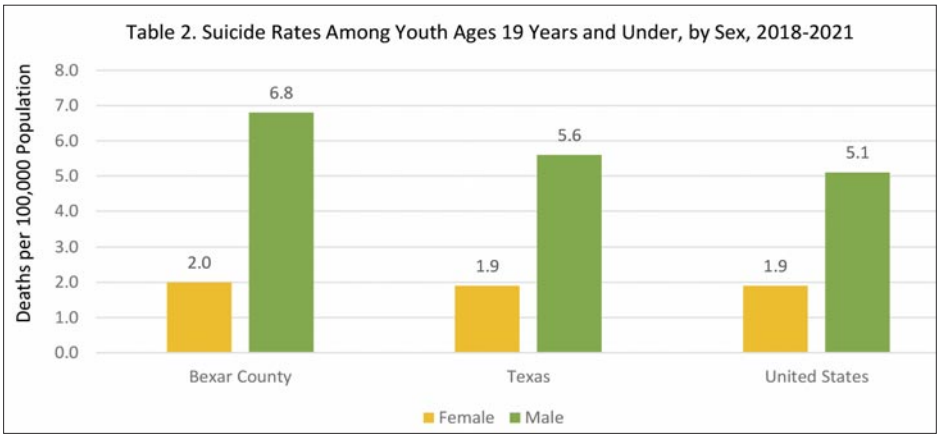


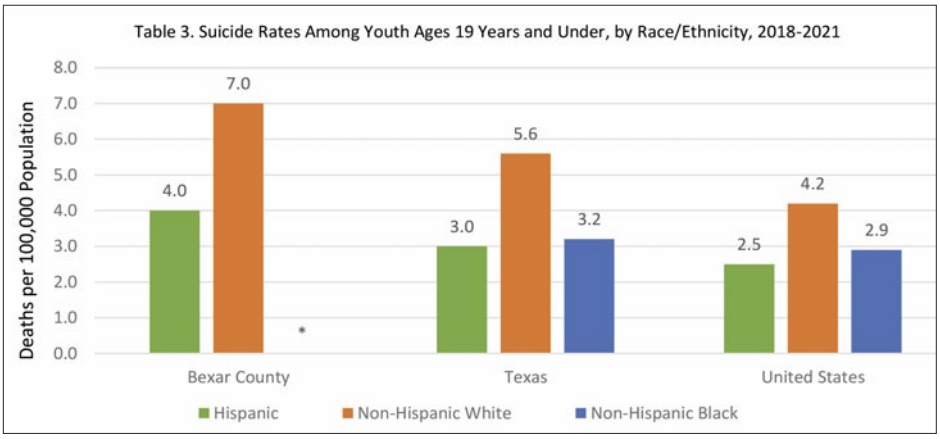
Suicide is a leading cause of death among youth in the United States[4] . Thus, suicide and suicidal behavior among youth are serious public health issues. Among high school students, 22% report having seriously considered attempting suicide in the past year, with 18% reporting having made a suicide plan during the past year, and 10% reporting having made a suicide attempt one or more times during the past year[4].

Between 2018 to 2021, the suicide rate among youth ages 19 years and under in Bexar County was higher than both the state and national suicide rates (Table 1). When looking at these same data disaggregated by sex, the suicide rate among females ages 19 years and younger was only slightly higher in Bexar County when compared to state and national suicide rates. Among males, however, the suicide rate was higher in Bexar County than the state and national suicide rates (Table 2). Looking at these data by race/ethnicity, the suicide rate among Hispanic youth and non-Hispanic White youth 19 years of age and younger was higher in Bexar County when compared with the state and national suicide rates for 2018-2021 (Table 3).

The devastating—and preventable—losses in life reveal real-time gaps in the nation's mental health services and disparities in access to treatment. To address these needs in Bexar County, the Mayor's Fitness Council developed a guide, "FIT from the Neck UP: A Mental Health Resource Guide," to provide mental health and suicide prevention resources to San Antonio parents and school personnel to support youth[5]. **The goals of the resource guide are to:**







- Increase understanding of mental health conditions and the treatment of mental health conditions in youth and young adults.
- Increase understanding of the problem of youth suicide, the risk factors that can lead to suicide, and the treatment and prevention of suicidal behavior in youth and young adults.
- Increase knowledge of mental health conditions, risk factors and warning signs for suicide, so that teachers, administrators, parents, guardians and adults who work with youth and young adults are better prepared to identify and refer students who may be at risk.

This comprehensive guide provides those supporting youth with information on how to increase access to mental health resources, reduce stigma, build resiliency and develop empathy to improve the mental health and well-being in our schools.

A resource from the American Foundation for Suicide Prevention (AFSP) and the American Academy of Pediatrics (AAP), in collaboration with experts from the National Institute of Mental Health (NIMH), is the "Blueprint for Youth Suicide Prevention"[6].

This comprehensive document aims to support pediatric health clinicians and other health professionals in identifying strategies and key partnerships to support youth at risk for suicide. Following a public health model, the Blueprint outlines the following universal, selective and indicated strategies that pediatric health clinicians can take to prevent youth suicide in clinical, community and advocacy settings[6], including:

- **Universal Strategies (i.e., Primary Prevention):** These strategies can be offered to all audiences across settings. Examples include speaking out against stigma, raising awareness, and educating patients and families about mental health and suicide prevention[6].
- **Selective Prevention:** Examples include screening patients in all healthcare settings for mental health concerns and suicide risk, facilitating a support group for at-risk youth, and partnering with schools to increase screening and support groups[6].
- **Indicated Prevention:** Examples include actively checking-in with patients about suicidal thoughts and behavior, offering care coordination, safety plans and follow up when treating patients for high-risk conditions (e.g., depression, anxiety, trauma, post-traumatic stress disorder (PTSD), eating disorders, other chronic medical conditions, pain, substance use or experiencing a loss to suicide)[6].
- **Treatment:** This includes optimizing treatment for any mental health condition and focusing on suicide risk as a separate but related clinical target. Examples include engaging with patients about their suicidal thoughts and providing specific clinical care steps, and providing lethal means safety counseling to patients and families when suicide risk is identified (See "Preventing Youth Suicide: Strategies for Clinical Settings" section of this Blueprint)[6].
- **Recovery:** Examples include following up with and supporting patients, ensuring they are continuing with mental health treatment or therapy, and fostering family or community-based support following a mental health or suicidal crisis[6].

continued on page 34

continued from page 33

This Blueprint is designed to support pediatric health clinicians in advancing equitable youth suicide prevention strategies in all settings where youth live, learn, work and spend time. There has never been a more urgent time for implementing effective suicide prevention initiatives, and these resources are available to support those working with teens and young adults across a variety of settings.

Early intervention is key for the development of healthy individuals, and it is important to educate youth as young as in elementary school to recognize signs of anxiety, depression and unstable mood. One out of five children face mental health conditions, and suicide is the second leading cause of death in youth starting at age 10. The connection between suicide behavior and untreated mental health conditions is well documented, with other sequelae of undetected or untreated mental health conditions, which include conflicts in interpersonal relationships, poor performance in academics/activities, school dropout rates, teen pregnancies, juvenile delinquent behavior and substance abuse. If left untreated, these issues often transition into adulthood. Furthermore, mental health conditions and suicide risk do not discriminate, effecting people of all ages, genders, races, ethnicities and socioeconomic and education levels. In fact, the suicide risk among physicians is high, with rates higher than that of the general population[7]. Stigmatizing attitudes towards mental health conditions and barriers to help-seeking remain prevalent within the medical profession and contribute to increased risk among this population[7]. Therefore prioritizing, planning and securing mental health education and services starting in elementary school years through high school and beyond is imperative to strengthening the mental health of all individuals. Targeting mental health education in the youth during their formative years will bring awareness to youth mental health needs and promote positive attitudes towards, and willingness to engage in, mental health resources and services, if needed. Ultimately, saving lives.

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Mrudula Rao, MD, is a Psychiatrist, Distinguished Fellow of the American Psychiatric Association, BCMS member, Physician Wellness Committee, Past President of Bexar County Psychiatric Society, Founding President of American Foundation for Suicide Prevention South Texas Chapter, Mayor's Fitness Council Executive Committee, Adjunct Assistant Professor, Department of Psychiatry at UT Health San Antonio.

Maggie G. Mortali, MPH, is the Vice President of Programs and Workplace Initiatives at the American Foundation for Suicide Prevention (AFSP). She leads the development and implementation of suicide prevention programs for large public and private sector employers, institutions of higher education and mental health service agencies, with the goal of reaching at-risk and underserved populations.

Contributors:

Golareh Agha graduated with a PhD in Epidemiology from Brown University. She has served as Chief of Informatics at San Antonio Metropolitan Health District since 2018, where she drives the mission of putting data, science and evidence into action within public health.

Tina Christi Lopez graduated with a Doctor of Pharmacy from The University of Texas at Austin. She serves as the Lead Health Data Scientist at the City of San Antonio Metropolitan Health District's Informatics Unit, where she utilizes data from largescale public health databases to assist the City with evidence-based decisions and policies.

In Memoriam

Anatolio Benedicto Cruz Jr., MD
Captain, MC, USNR (ret)

June 20, 1933 - May 21, 2023

Dr. Cruz was a founding faculty member of the University of Texas Medical School at San Antonio and a renowned oncologist and surgeon. He served as a surgical instructor, professor and founding chief of surgical oncology. As a leader in breast oncology clinical trials and an author of numerous studies, Dr. Cruz revolutionized breast cancer treatment.

David Anthony Hnatow, MD

May 25, 1959 - May 16, 2023

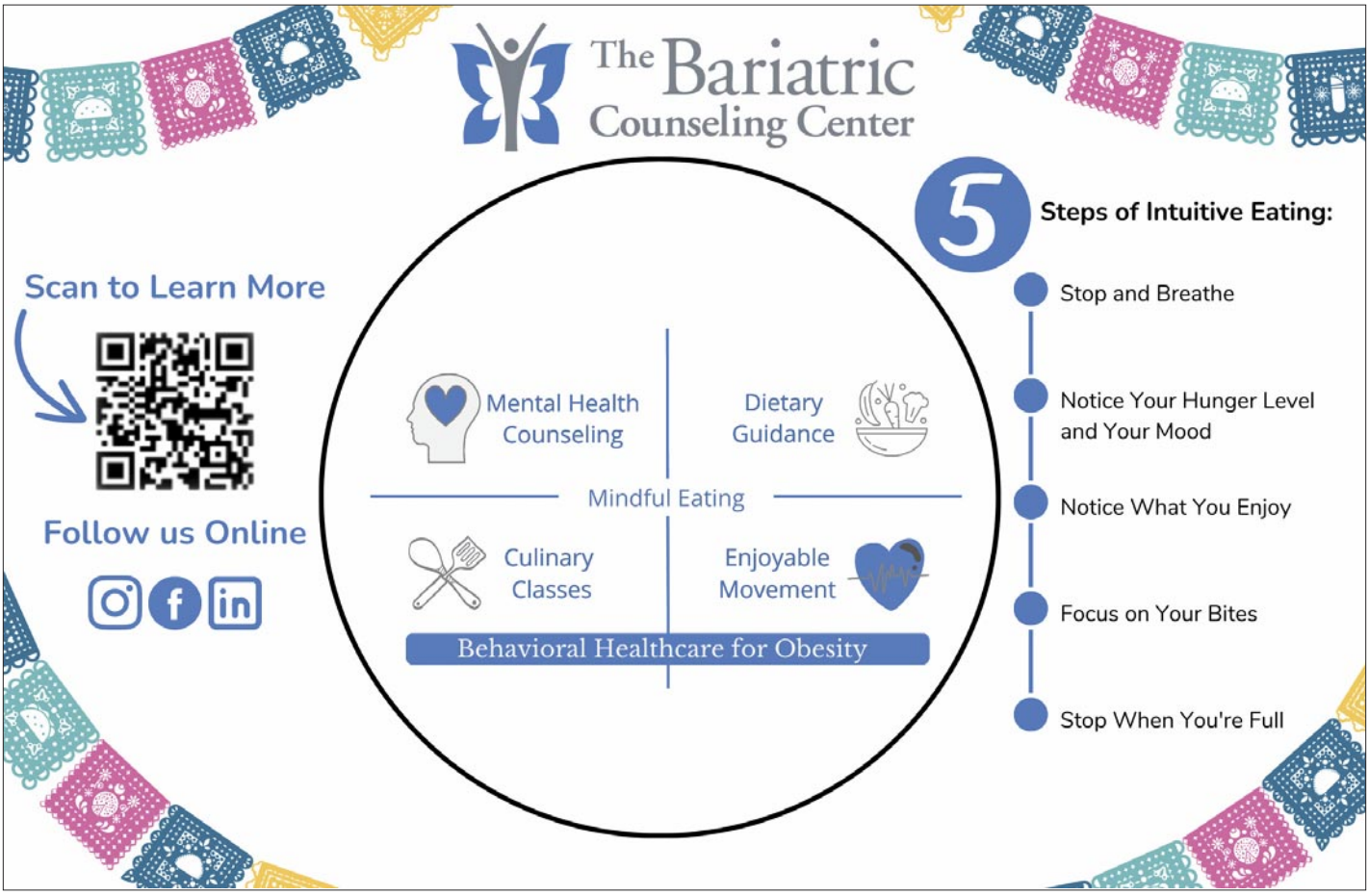
Dr. Hnatow was dedicated to service to our community and BCMS. He had been a member of BCMS since 1991 and was active the entire time, including most recently serving on the BCMS Board of Directors. He served on the BCMS Disaster Medical Response/Disaster Medical Care (1994-1998), the BCMS Emergency Medical Services Committee (2004-2009), the BCMS Emergency Preparedness Committee (1999-2023), the BCMS Board of Mediations (2013-2018), and the BCMS Delegation to TMA (2013-2023).

"Boulder Beach" by Oliver Johnson, Jr, MD

I took this in Bolder Beach in Acadia National Forest in October 2021. We had to get up at 0400 to beat the sunrise, climb down a somewhat perilous rocky trail to get to the beach, find a spot among the other photographers and sit on these rocks for several hours with a tripod waiting for the light to get perfect. I didn't think to bring a pillow to sit on, so I had to endure it. But it was worth it, I think. The leaves in Maine were turning and it was just gorgeous. Knowing what time of year, what place and the time of day is key to good landscape photography.

Oliver Johnson, Jr, MD is a retired Anesthesiologist who dedicated 30 years to the medical field. Since 1995, he has chaired the BCMS Physicians Health and Rehabilitation Program. Dr. Johnson's passion for photography takes him on photo trips around the world where he is surrounded by professional photographers who teach and advise. He currently shoots with a FUJIFILM X-T4 Mirrorless Camera.

Cuatro de Mayo Business Mixer & Interactive Culinary Experience: Thursday, May 4, 2023



BCMS Members spent Cuatro de Mayo with the Bariatric Counseling Center of San Antonio chefs who educated us on how to prepare delicious and healthy meals.

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TexMed 2023:
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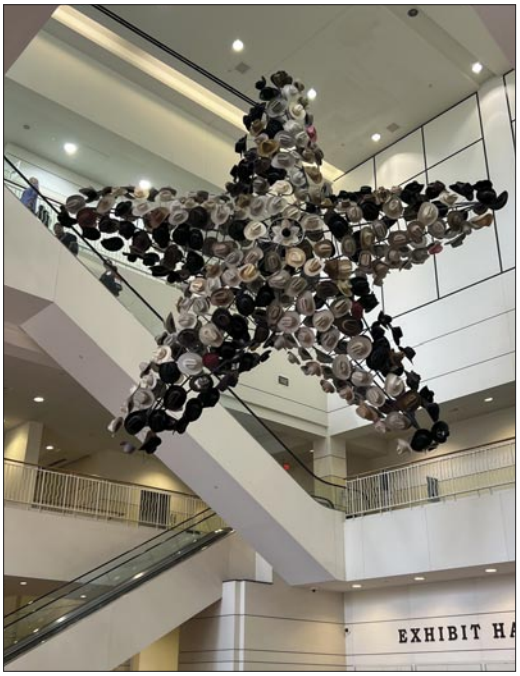
TexMed 2023 took place in Fort Worth, May 19-20. As the TMA's largest annual conference, TexMed brings together physicians from around the state to attend and participate in business meetings of TMA committees, councils and boards, CME seminars, House of Delegates business meetings and elections, in addition to providing a variety of networking opportunities and events.

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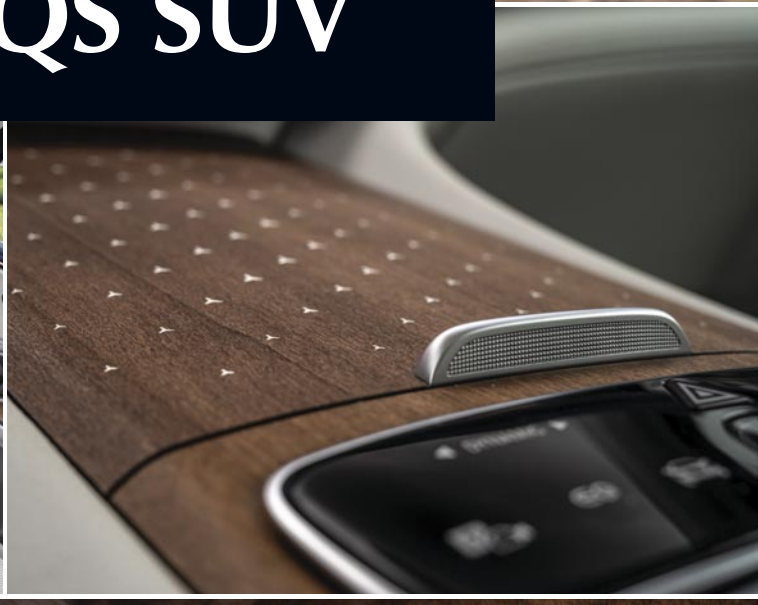
AUTO
REVIEW

2023 Mercedes EQS SUV

By Stephen Schutz, MD



The (soon to be re-named) 2023 Mercedes EQS SUV is the German luxury automaker's first attempt at making a top-shelf all-electric luxury SUV. It's a good first try, but Mercedes' promised name change can't come soon enough—you have to call it the EQS SUV because there's also an EQS sedan, so you can't call either version, "a Mercedes EQS." Weird.

Anyway, as the automotive industry continues its shift towards battery electric vehicles (BEVs), Mercedes-Benz is determined to keep up. Their latest offering, the 2023 Mercedes EQS SUV (mostly) combines the elegance and opulence associated with the Mercedes brand with the latest in electric technology.

The EQS SUV's exterior design looks very aerodynamic and futuristic. From every angle it is clear that Mercedes stylists and engineers made certain that drag was minimized—it's a technical marvel, actually. However, while undoubtedly effective in cheating the wind and optimizing power savings, the EQS SUV lacks the presence that its stablemates, the internal combustion (ICE) powered S-Class sedan and GLS SUV, have. An important part of Mercedes design over the many decades of the automaker's existence has been to signal to other drivers, sotto voce of course, that an important person is coming through. The EQS sedan and SUV need more of that, I believe.

Oh, by the way, the EQS SUV is essentially a lifted EQS sedan with a rear hatch. The two share a platform and many other components and have identical wheelbases, but the SUV offers a third row of seating for up to seven passengers.

There are two versions of the EQS SUV available, the 355-HP EQS450+ (I have no idea why there's a plus sign there) and the 536-HP EQS580. The 450+ gets you up to 305 miles of driving range per charge, while the 580, like my test car, gives you 285.

For the record, the starting price for the cheapest EQS 450+ is $105,550, while a loaded EQS 580 goes for, gulp, $133,350. These are expensive vehicles.

Regardless of which EQS you select, the instant torque from the stout electric motors allows for smooth and exhilarating acceleration, propelling the EQS SUV from 0 to 60 mph in just a few seconds (4.2 seconds for the 580, to be specific).

With a curb weight of just under 6,000 pounds, the EQS SUV can only be described as portly (a base Chevrolet Suburban weighs less). Still, in most normal driving situations Mercedes' first BEV SUV handles just fine, and definitely better than a Suburban.

The EQS SUV's interior features mostly high-quality materials, including premium leather, genuine wood and real metal accents, all meticulously crafted to create a luxurious atmosphere. Nevertheless, there's less of a luxe feel in the EQS than there is in its Mercedes ICE counterparts.

The EQS SUV provides ample head- and legroom for both front and rear passengers. The first two rows of seats have excellent comfort and support, ensuring a pleasurable "Mercedes" experience, even on long journeys. As you might expect, the third row is just for kids or very short trips.

Mercedes-Benz has reimagined the traditional dashboard layout, replacing it with a massive curved OLED display that stretches across the entire dash area. This (optional) 56-inch "Hyperscreen" display combines the instrument cluster, infotainment system and climate controls into a seamless user interface, which is not only visually stunning but also intuitive to use. Having said that, the Hyperscreen replaces almost every knob and button, which can be a little disconcerting until you get used to it.

As expected from a flagship Mercedes-Benz model, the EQS SUV is packed with cutting-edge technology. The Hyperscreen mentioned earlier is the centerpiece of the vehicle's tech arsenal, offering many customization options and access to any feature or function you might need. It is complemented by the latest iteration of the Mercedes-Benz User Experience (MBUX) infotainment system, which provides excellent smartphone integration, voice control and a host of other intelligent features.

Naturally, the EQS SUV is equipped with an extensive suite of driver assistance/safety systems including adaptive cruise control, lane-keep assist, automated emergency braking and pedestrian detection.

Before buying a Mercedes EQS or any other BEV, think about how you'll use it. If you have a home charger, commuting and running errands in a BEV, are fine, but long trips may be problematic. JD Power and the Wall Street Journal® have recently reported that the charging infrastructure isn't what it should be to support long trips in a BEV, and outages at existing charging stations are an increasing challenge.

The 2023 Mercedes EQS SUV is a standout premium electric SUV that blends elegance and excellent drivability. With its lush interior and advanced technology, it brings Mercedes-Benz luxury to the BEV SUV game, although I wish it had a more imposing exterior design. Plus, I'd like to see Mercedes give it a better name sooner rather than later.

As always, call Phil Hornbeak, the Auto Program Manager at BCMS (210-301-4367) for your best deal on any new car or truck brand. Phil can also connect you to preferred financing and lease rates.

Stephen Schutz, MD, is a board-certified gastroenterologist who lived in San Antonio in the 1990s when he was stationed here in the U.S. Air Force. He has been writing auto reviews for San Antonio Medicine magazine since 1995.

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