The Medical Society of the County of Queens
and The Academy of Medicine of Queens County

BULLETIN

Volume 12 • Issue No. 4 | *Over 200 Years of Service to the Medical Community of Queens County* | *Winter 2020-2021*

Inside This Issue

Letter from the President's Desk

Dear Friends
and Colleagues,

Good day all. These have been some troubling times recently, but I will confine my remarks to matters of medicine and healthcare. The COVID pandemic has caused much grief to all of us since ten months ago, and MSSNY has lately come up with a strategy to help out in dealing with this.

New York State government has placed specific guidelines and procedures in place regarding the distribution of the vaccines and who is to be vaccinated. Although a healthcare facility based in Brooklyn attempted to circumvent those guidelines, they were stopped by the authorities and are undergoing criminal investigation. The message should be clear to all of us - follow proper procedures and obey government regulations.

A suggestion was made to me that the Queens County Medical Society could offer to obtain vaccines to provide to physicians; both members and non-members. It was suggested that such an initiative might help to acquaint physicians with the mission of the Society and reinforce the importance and relevance of Society program's to physicians and the communities we serve. It might also reengage member physicians who have become apathetic or who question the value of having the Society in the first place.

The suggestion was most admirable but not practical as the Society has no place to properly store any medications nor any appropriately trained staff to administer them. However, we did discover a meaningful way for the Society to be of service to the effort to eradicate the COVID-19 virus. We have the means to reach out to all physicians and the general public with public service messages advocating the safety of the vaccines and encouraging all to follow the procedures and get the vaccine when the government allows. We can educate all and be a resource for physicians whether or not they are affiliated with a hospital or medical network to obtain what they need.

By working with the government on this problem posed by the pandemic, we, the Medical Societies, can show them the value that we have and possibly convince them to eliminate or modify in our favor some of the more restrictive laws and regulations that have been placed on physicians recently.

We all can agree that showing our elected officials that we are valuable to the people in our communities will convince them to see us in a more positive way.

I hope that we can safely get through this pandemic. As we all know some have lost family or friends to it. I, myself, had COVID-19 back in March of last year, and it is very serious.

Together we can make progress and get through this thing. At a few society meetings, many great ideas have come up from the membership, which I greatly appreciate. Many have knowledge of something beneficial, but due to shyness or some other thing, do not speak up - let us hear your voice. Gold that is still buried in the ground does nothing for anyone.

Thank you, and stay safe.

David Vilabrera, MD,
President

MEETINGS / CME / EVENTS

Meetings	Date / Time
MSCQ Board of Trustees Meetings All Board of Trustees Meetings are held on the 1st Tuesday of the month via Zoom, unless noted. Dates may change.	February 2, 2021 • 6:00 pm March 9, 2021 • 6:00 pm April 6, 2021 • 6:00 pm May 4, 2021 • 6:00 pm June 1, 2021 • 6:00 pm
Comitia Minora Leadership Meetings All Comitia Meetings are held on the 1st Tuesday of the month via Zoom, unless noted. Dates may change.	February 2, 2021 • 8:00 pm March 9, 2021 • 8:00 pm April 6, 2021 • 8:00 pm May 4, 2021 • 8:00 pm June 1, 2021 • 8:00 pm
First District Meetings Via Zoom, unless noted.	January 28, 2021 • 7:00 pm
MSSNY Council Meeting Via Zoom, unless noted.	March 1, 2021 • Details mssny.org
MSSNY House of Delegates Via Zoom, unless noted.	September 18, 2021 • Details mssny.org
AMA Meeting	June 12-16, 2021; November 13-16, 2021

Upcoming Events

Live CME activities presented by Lorraine Giordano, MD, FACEP, FAADM

▶ **"End of Life Guidance" (via ZOOM)**
Tuesday, February 2, 2021 • 8:00 pm
***.5** AMA PRA Category 1 Credit(s)™*
Registration / Information: MSCQ • 718-670-7300

▶ **"Addressing the Rise of Suicide Rates in the U.S." (via ZOOM)**
Tuesday, April 6, 2021 • 8:00 pm
***.5** AMA PRA Category 1 Credit(s)™*
Registration / Information: MSCQ • 718-670-7300

MSSNY's Physicians Advocacy Day
Tuesday, March 2, 2021 • 8:00 am - 11:00 am
Information: Raza Ali, Legislative Associate. Rali@mssny.org

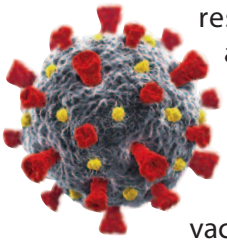
Details and ZOOM registration ⇨ page 13.

For information about placing a CME program listing, please contact 718.268.7300.

DO NOT Throw Away Your Shot!

Joseph T. Cooke, MD,
Secretary & Publication Chair

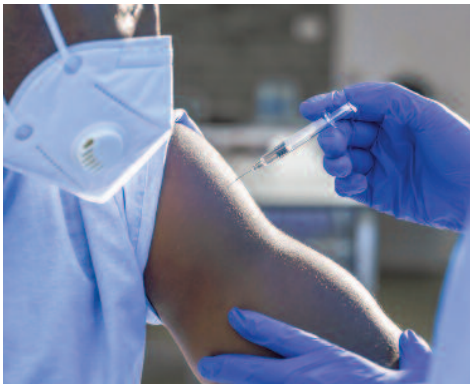
While we were battling COVID-19 this summer, something remarkable happened. Polio, the deadly virus that



results in paralysis and respiratory failure was eradicated from Africa. How was this done? Contact tracing and vaccination. The same way other serious viral illnesses, such as measles, mumps and rubella have been brought under control, the same way we are going bring the SARS CoV 19 virus under control.

Vaccination is the key.
At NewYork-Presbyterian Queens, we have delivered almost 4000 vaccines to staff, a prominent number but disheartening in that many of our nurses, aides, and support staff are choosing to wait or not get vaccinated at all. I was even more devastated by the misinformation being spread and believed over the actual published science. We the members of the Queens County Medical Society must be dedicated to decrying the misinformation, educating our staff and patients about COVID-19 vaccination.

Queens County has been terribly afflicted by COVID-19. We have lost family members, colleagues, as well as members of our own Society. Data published January 10th showed 1549 newly reported cases and 17 deaths in our County. 7652 deaths since the start of this Pandemic. The COVID-19 inpatient census currently at my hospital is over 200 representing 50% of the inpatient Medical Service. Our staffing is stretched. We are stressed. We are tired. As we focus our resources on those with COVID-19, we are not focused on the care for those with heart disease, diabetes, COPD, cancer among other illnesses. We need to get COVID-19 under control. The COVID-19 vaccines approved in the United States have been shown to be highly effective in preventing COVID-19. Only two are approved at this time Pfizer – BioNTech, and Moderna's. Three Phase 3 trials are underway for AstraZeneca's, Janssen's, and Novavax's. All are being carefully evaluated. Although technology has allowed their rapid development, safety and efficacy determination process by the FDA was in no way compromised.



COVID-19 vaccination will protect you from getting COVID-19. Two doses are required to afford the maximal protection. Supply of vaccine is limited. This forced difficult recommendations as to whom to vaccinate first. Supplies will be increasing with the release of the U.S. Stockpile, and increased production in the coming weeks to months. No vaccine is completely free of side effects. Having arm soreness, fever, or even feeling like you have the flu are not unusual and a sign that your body is building the needed protection. The vaccine can not make you sick with COVID-19.

COVID-19 vaccination is one important tool to help stop this pandemic. We must continue to use the other tools available to us. Use a mask, socially distance from others, avoid crowds and small family gatherings with those not in your personal "Bubble." Become educated. Make sure the information you are getting on the Internet is coming from a reliable source. **CDC's vaccines safety site is one of WHO's 20 English language certified web sites.** CDC's vaccines and immunization web content is researched, written and approved by subject matter experts, including physicians, researchers, epidemiologists, and analysts. Content is based on peer-reviewed science. CDC leadership makes the final decision on the words, images and links to best serve the information needs of the public as well as healthcare providers, public health professionals, partners, educators, and researchers. Science and public health data are frequently updated. **The NYC Department of Health COVID-19 Site** is chock full of up-to-date statistics right down to a neighborhood's zip code.

NYC DOH Covid-19 Site:
https://www1.nyc.gov/site/doh/covid/covid-19-data-neighborhoods.page
NYC Vaccine Finder: (find site near you)
https://vaccinefinder.nyc.gov/

As I am writing this 267,923 vaccine doses have been administered in New York City. A great number, but 525, 752 of the doses delivered have not been administered. We, the Queens County Medical Society must do whatever we can to promote COVID-19 Vaccination.

With apologies to Lin-Manuel Miranda, do not let our patients, friends, family, staff, and ourselves "Throw away their Shot!" ■

About the Author

Joseph T. Cooke, MD
Chairman, Department of Medicine, NewYork-Presbyterian Queens; Vice Chairman, Weill Department of Medicine; Secretary & Publication Chair, Medical Society of the County of Queens

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Checklist to Mitigate Risk with Telehealth

During the COVID-19 pandemic, telehealth encounters have been essential to providing care. While telehealth services may be necessary, there is always a concern that using this technology may lead to liability exposure.

The following is a checklist of factors to consider when using telehealth for the treatment of patients:

Is this an appropriate patient for a telehealth encounter?

- If not, recommend a traditional office visit.

Was consent obtained for the telehealth encounter?

- It must be documented in the chart and/or obtained with a signed form, if possible.

Where is the patient located?

- As telehealth services are delivered where the patient is located, licensing issues may exist for care being provided to a patient located in a state where the practitioner is not licensed.

How is the video/audio quality?

- Poor audio quality can result in a lack of communication and misunderstandings.
- Poor video quality can result in potential misdiagnosis.

Is the encounter properly documented in the patient chart?

- Create, maintain, and update medical records as you would an in-office visit.

Is HIPAA-compliant technology being used?

- Enter into an appropriate Business Associate Agreement.
- Use a platform/network that encrypts data for end-to-end protection during the telehealth transmission.

Does the telehealth encounter mirror an encounter in the examination room?

- Ensure the patient is in a secure location where exchanges are not audible to others.
- No one should be present at the practitioner's location that should not be privy to the encounter.
- Consider the presence of a chaperone for encounters of a sensitive nature.

Is there a proper plan in place for recommendations and follow-up?

- Adhere to the same follow-up requirements as in-office visits.

Written by:
Danielle Mikalajunas Fogel, Esq.
Fager Amsler Keller & Schoppmann, LLP
Counsel to MLMIC Insurance Company

Retaking Our Profession: Some Considerations

Louis-Joseph Auguste, MD, MPH, FACS,
Chair/Board of Trustees, MSCQ & AMQC

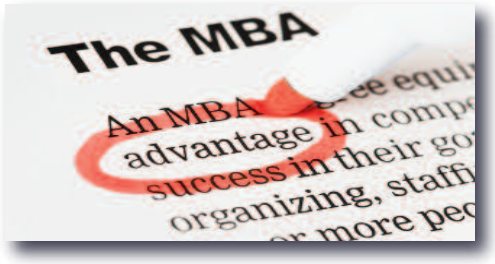
A resident in Anesthesiology, about to complete his training, recently wrote: "I'm in the wrong era of medicine to be a doctor... While I am happy to move on and begin practicing on my own, I am also somewhat terrified of what lies ahead. It's not caring for patients that I am afraid of, but the cultural state of medicine in the 21st century that I am worried about." Many of us, who have been practicing for a while, have felt the same way and cannot quite understand or adapt to what is being presented as the new standard of care, the best way to practice medicine. Having joined a profession, as old as mankind, a profession which has grown through the selfless efforts, the dedication and the sacrifices of so many of our forbearers, we are being told that everything that we know, everything that we are doing is wrong. Everything from caring for patients to teaching the next generations of physicians. We are being told by whom? Government, Insurance companies, Administrators, economists and at times by our own colleagues who often decide to join "them" since they cannot fight "them." Every other profession wants a piece of the pie. Pharmacists, Nurse Practitioners, Physician Assistants, acupuncturists want to be a "doctor," using a shortcut, without taking the time or the pain to be a real one, without sacrificing years of their lives to become one. These health workers who used to be complementary to the medical profession, no longer want to work side by side with the physicians. They want all now to lead the physicians and the entire health care system. Physicians, who have spent so much time learning how to decipher the many hidden forms and presentations of human illnesses and how to treat them and who are always the last recourse when things get "really bad," are being pushed back and brought down to the level of "providers," while the NP's and the PA's are designated now as "Advanced Care Providers."

All these transformations are taking place through the advocacy and lobbying of the professional associations of these groups. Physicians are being told that they are wasteful! They are responsible for the health care crisis! They do not have any managerial skills!

The response of physicians so far has been either to play nice and progressively relinquish their prerogatives or to stoically absorb all the blows and hope that things will change. I believe that both attitudes are suicidal. All the wonderful promises of politicians, health economists, IT specialists, strategists have not panned out and delivered the promised goods. It is time that physicians regain their seats at the table. It is time that they retake charge of their profession and of the health of their society and of the world.

The Workers' Unions understand well the need to promote their members to higher levels in the workforce, by financing their studies. Hospital administrations help defray the cost of the education of the nursing staff and members of their staff. It is time that the Staff Society takes the lead in encouraging members of the staff to enroll back in Universities to obtain degrees such as MBA, MPH, MHA, MHCDS, MPA etc… to keep a foot in the door of administration and keep the focus on the human side of medicine. Physicians need to do it in large numbers so that they can no longer be ignored or passed over for leadership positions in health care.

This process of honing our skills in management will be time consuming. It will require sacrifices of time and efforts. It will be costly. However, those



who are willing to take that path toward driving forward a more physician friendly, a more patient friendly agenda, will be the true leaders of tomorrow, the true saviors of the profession and the guarantors that a patient-centered system will remain our priority and that the delivery of medical care will not become an accounting exercise, another heartless endeavor of venture capitalists.

All physicians, independent or salaried, need to come together, unite their whispers and their painful groans into a common message, a common voice, that of their county, state or national medical societies. I often hear physicians complain that the AMA has not done anything for them. To them, I would reply: What have you done for MEDICINE yourself? You can be a bystander and continue to bemoan the decline of our noble profession or you can join in the fight to defend all your years of studies and training that position you to be the real leader of the health industry. The future of the profession depends on us.

The future of health care in the country depends on us. ■

About the Author

Louis-Joseph Auguste, MD, MPH, FACS, Surgical Oncology/ General Surgery; Clinical Professor of Surgery, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell; Chair/Board of Trustees, Medical Society of the County of Queens

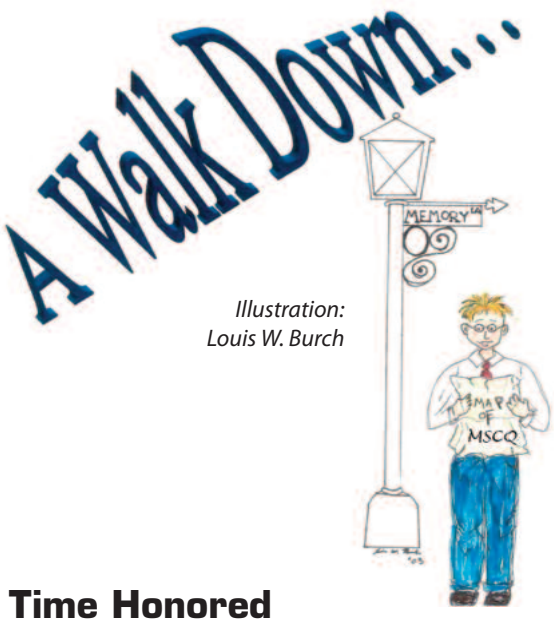


Illustration: Louis W. Burch

Time Honored

For decades the BULLETIN newsletter has been providing information to members of the Medical Society of the County of Queens and the Academy of Medicine of Queens County. While the publication has gone through a series of iterations to keep pace with the changing times, the BULLETIN remains a valued resource for physician updates and Society and Academy initiatives. Our current BULLETIN is an interactive online publication and an ideal way to connect with colleagues, list or register for upcoming CME activities, and submit articles, announcements or advertisements. If you would like to share vintage photos, documents or stories related to the history of the Medical Society, please e-mail them to: QMS@QueensMedicalSociety.org ■

Excerpt of Keynote Address to the Medical Scholar Pipeline Graduates

Louis-Joseph Auguste, MD, MPH, FACS, Chair/Board of Trustees, MSCQ & AMQC

Hofstra Northwell School of Medicine (July 21, 2016)

Excerpt from the inspiring MSSP closing ceremony keynote address by Louis-Joseph Auguste, MD, MPH, FACS, Clinical Professor of Surgery at the School of Medicine and Surgical Oncologist at Northwell Health.

"Thank you for this nice introduction. I thank you for giving me the privilege and the honor to be the keynote speaker, to be the one to salute the accomplishments of these incredibly smart young men and women, completing this wonderful and empowering program of Medical Scholars Pipeline. However, this evening is not about me. It is about a message! It is about you Pipeline Scholars. If I fail to connect with you, your hopes and your aspirations, I will be forgotten as soon as you walk out of this auditorium. My ambition is that 20 years from today, you will remember one thing or two from this speech, perhaps an idea, a piece of advice that will make a difference in your lives and will be a guiding principle in your careers.

To make it simple, I will divide my address in five segments that you are all too familiar with:

Who? What? When? Why? And How?

First, this evening ceremony is about WHO?

Certainly, we have to thank Dean Smith for leading such initiative within the Hofstra Northwell School of Medicine. Congratulations are also in order to all the faculty members and organizers, particularly Gina Granger, for making this program so successful and giving you this opportunity for intellectual growth and development.

However, this evening is mainly about you, the most important individuals in this room.

Give yourselves a big pat in the back, because of your hard work, because of your determination, because you have chosen to ignore the temptations of laziness and complacency, because you have chosen instead to seize every opportunity to better yourselves.

Make no mistake about it. You are the privileged ones. You are the torchbearers. You will be the leaders of tomorrow. You will be the agents of change."

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Microaggressions: The Consequences Can Last A Lifetime

Penny Stern, MD, MPH, FACPM, FACOEM,
Past President - MSCQ 2016 - 2017

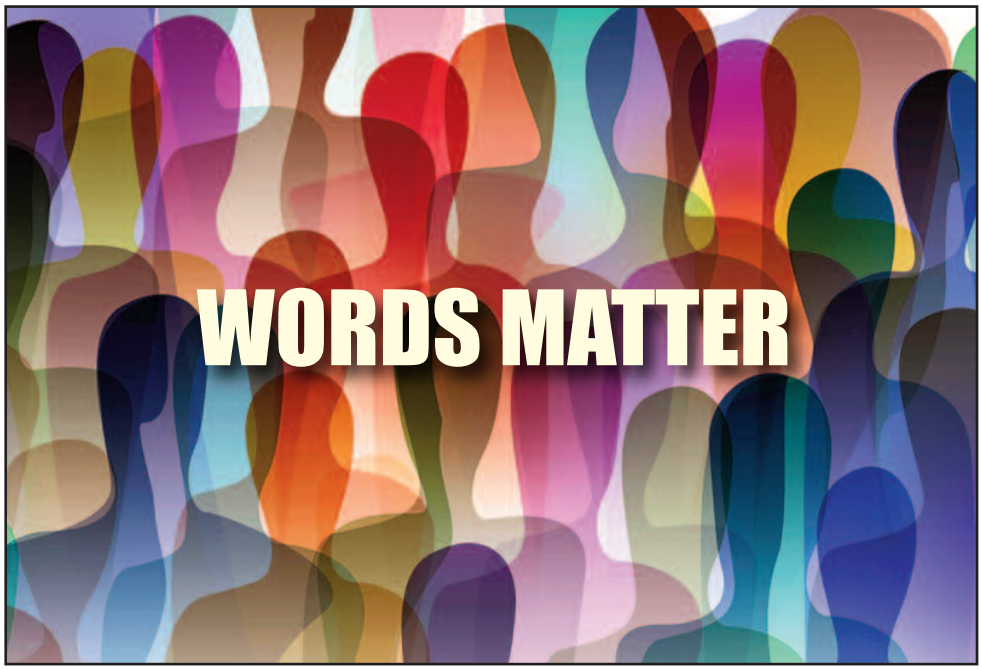
The term **'microaggressions'** has recently come to the attention of many, but the word is actually not a new one – it was first used in the 1970s by Dr. Chester Pierce, an eminent Harvard professor and psychiatrist, who used it to describe what he saw as the insults directed towards African Americans.

Two decades later, another professor, Derald Wing Sue, PhD at Columbia University's Teachers College, expanded on Dr. Pierce's work, by defining microaggressions as the "denigrating messages" that are delivered, often subtly and sometimes without fully realizing their impact, to members of various groups because of their being part of those groups. According to Professor Sue, microaggressions can be divided into three subsets:

- **Microinsults**
- **Microassaults**
- **Microinvalidations**

Microinsults are the most common form of microaggressions – these are the comments or gestures that are often not recognized by the microaggressor as the insensitive insults they are. Microinsults can demean a person's racial, ethnic or gender identity. These can take many forms, such as asking a person of color how he got his job (the implication being that something other than qualifications was involved). Or, saying something like, 'your name is too hard to pronounce. Can't I just call you Jane?' Or, using the word, 'gay' to mean 'stupid.'

Or, when Joe Biden commented in 2007 about then-Senator Barack Obama, "I mean, you got the first mainstream African-American who is articulate and bright and clean and a nice-looking guy. I mean, that's a storybook, man," that was a microinsult.



Microassaults is the term applied to actions such as painting swastikas or hanging a noose. Violence is implied through these behaviors. Microassaults are much more overt than the more usual, commonplace microaggressions.

Microinvalidations are comments that seemingly invalidate the expressed thoughts or feelings or experiences of a person from a marginalized group. With microinvalidations, the implication is that a person's experiences cannot be true, because we now live in a world that doesn't 'see' color or because everyone supposedly has the same chance for success. ("The myth of meritocracy," according to Professor Sue). People are invalidated when they are made to feel that they are never accepted for who and what they are.

The consequences of microaggressions can last a lifetime. So, it's important to recognize microaggressions for what they are and to interrupt them. It's not a matter of calling someone a racist or a sexist or any other term– rather, it's about letting the microaggressors know that their comments are hurtful and why. It's helping them to see the impact of their words. It's not about inciting anger but about supporting empathic communication.

Ask a person what they meant by their words and explain what you heard and how it made you feel. Do everything you can to support the kind of society where everyone can be comfortable, where diversity and inclusion are lived every day. ■

About the Author

Penny Stern, MD, MPH, FACPM, FACOEM, Past President- Medical Society of the County of Queens 2016 - 2017; Director, Preventive Medicine, Department of Occupational Medicine, Epidemiology, and Prevention; Immediate Past President, Faculty Council, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell Center for Equity of Care - Katz Institute for Women's Health; Co-Chair CME Committee, Northwell Health

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Transformation in Economic Models of Health Care

Louis-Joseph Auguste, MD, MPH, FACS,
Chair/Board of Trustees, MSCQ & AMQC

Is health care a right or a privilege? This question has weighed heavily on the mind of the leaders of this country for a century, and since Franklin D. Roosevelt, many attempts have been made to provide access to health care to all Americans despite staunch opposition from those who believe that health care should be a privilege. The first effort towards that goal was taken when President Truman, through a program of tax exemption, encouraged commercial enterprises to provide health insurance to their employees. The second major step followed in 1965 with the enactment of the Medicare/Medicaid Law. These commercial or government-sponsored plans reimbursed the care provided by hospitals, physicians, and other health care providers on a fee for service basis. As could be expected, this system spurred an ever-increasing level of consumption. In the early 1980s, concern was raised over the escalating cost of health care, representing at that time nearly 10% of the national budget. The managed care concept was embraced as a possible solution to this looming crisis. Managed care was based on a gatekeeper system, whereby all visits to a specialist would need to be authorized by the primary care provider. The latter was incentivized to minimize these expenses through a monetary bonus provided at the end of the year after a review of his or her practice pattern. The system failed, and the overall cost of health care continued to escalate. The idea of capitation was floated and tried for a while. In a capitated program, a given number of individuals are assigned to an individual or a group practice who will provide all routine care for a flat fee, whether or not the individual receives any service. This approach was marginally successful and is still in operation in certain regions of the country. However, at the macroeconomic level, this has failed to stem the tide and significantly reduce the cost of health care. The latest major attempt to control the cost of health care and simultaneously extend the benefits of health care to the entire population came in 2010 under President Obama, in the form of the Affordable Care Act. Although the discussion has focused on the five buckets of provision designed to extend medical coverage to the entire population, other regulations aimed at improving quality through the implementation of meaningful uses and at controlling the rise in cost by limiting the percentage of premiums spent on administrative fees. The other less discussed aspect of the ACA is the creation of ACO or Accountable Care Organizations as a way to provide a medical home to those in need with the integration of the health care services. These features of the ACA may constitute the backbone of what the future of health care in America may look like: Care that is affordable and accessible to all and that focuses on quality and not on the quantity of interventions. That vision is presently quite remote from the current state of affairs since the U.S. spends the most per capita for health care in the world and lags behind many other developed countries and even some underdeveloped countries, when it comes to statistics like materno-infantile mortality, child vaccination, etc...

Lest we want to deal with sterile fantasies, any discussion on the future of health care in America must take into account the local reality, the context in which these measures are expected. Thus, we could discuss what cannot be changed and what needs to change.

Indeed, the two biggest poles of risk and needs in health care are the old and the poor. For the past 10 years, baby boomers have been reaching retirement age at an unprecedented pace: 10,000 every day, for a total of 80 million over the next 20 years. This reality is unavoidable. As this population grows older, so will grow the need for long-term care for age-related illnesses and disabilities, arterial hypertension, arteriosclerosis, Diabetes mellitus, arthritis, congestive heart failure, strokes, dementia, and Alzheimer's disease. So will also grow the need for home companions, senior-assisted living quarters, retirement facilities and nursing homes. As these elderly Americans start experiencing increasing levels of disability or limited mobility, access to physicians and facilities becomes

- continued on page 11

Transformation in Economic Models of Health Care *continued from page 10*

Louis-Joseph Auguste, MD, MPH, FACS,
Chair/Board of Trustees, MSCQ & AMQC

problematic, hindering the delivery of care, even when insurance coverage is adequate.

The other extreme, that can and should change, is the plight of the poor, who have to worry first about the primary necessities of food, shelter and safety. These individuals have to deal with countless and ever changing regulations determining their eligibility or lack thereof of government subsidies. A Medicaid insured individual today may find him or herself ineligible tomorrow if they land a job with a salary above a certain level. If the unskilled worker is a day laborer, he or she can ill afford to take a day off from work to see a physician or take his or her dependent family member to see a physician between 9 and 5 o'clock, adding to the cost of care, without necessarily having any impact of the patient's chronic condition. Therefore, preventive care is skirted, the Emergency department is used in lieu of a primary care physician and no follow up care is given.

This grim reality is further darkened by a prevailing sedentary lifestyle centered around the omnipresent television and fast food. As a result, two thirds of the population is overweight and one third is obese. This obesity epidemic affects particularly the southern states where two thirds of the population are obese, with all the associated complications of diabetes, hypertension, arthritis, vascular diseases, renal failure and premature death. To this, we have to add the scourge of recreational drugs plaguing both the inner city and the rural communities where the rate of deaths of drug overdose has reach alarming rates. The picture would not be complete without a mention of the gun obsession in this country, further complicated by the prevalence of stress and mental illness.

The other leg of our reality is that this country is essentially a capitalistic society, where industries are focused on maximizing profits at all cost. The price of drugs, particularly in the case of biologic therapy, has skyrocketed to unprecedented levels of several thousands of dollars per pill or per injection. The same goes for medical devices, which are not only extremely expensive, but are sold at a higher price in the United States than in Canada or Europe. At last, we would be remiss if we did not discuss the commercial insurance plans, more concerned with the returns to their shareholders or the pockets of their CEO and administrative staff.

Once a complete review of the system along with its flaws has been completed, we can start envisioning what would be the desirable characteristics of a better health care system. First, it is important that universal insurance coverage be provided from cradle to grave. This will prevent any interruption or disruption in the flow of care, either because of change in the individual's employment or economic status, or because of migration between cities or from state to state.

Second, the ideal system will be patient centered, with a medical home for every individual or family. This medical home should be fully integrated with either a multispecialty group or a close network of physicians and advanced care providers with interconnected electronic health records. This medical home would have all the features of an ACO and would be geared toward prevention and maintenance of health. Evidence-based recommendations would be adopted and enforced for most chronic conditions that have been shown to benefit from close monitoring, close surveillance and a proactive approach. That list includes:

- AIDS/HIV
- Arterial Hypertension
- Asthma
- Congestive Heart Failure
- Depression and Anxiety disorders
- Diabetes mellitus
- Obesity
- Pregnancy
- Strokes
- Well-baby care and vaccinations

These medical homes should be implanted in all neighborhoods and accessible day and night, in order to provide services to the working parents or the students who are not at leisure to frequent the office during the daytime or the weekdays. This navigator will also see that the patient in need of such service receives adequate and convenient transportation. The navigation team will also monitor the compliance with prescribed medications through verification of pharmacy records.

Quality metrics based more on outcome than on process will be established and the achievement of these goals will constitute the ultimate determinant of this Value-Based Reimbursement Program, focused on the maintenance of health in the population.

Elective specialty care, such as joint replacements or cataract extractions, should be delivered by hospital facilities and clinicians meeting defined standards in the delivery of the given field. Narrow panels of specialists should be constituted who render the optimal results at the most cost-effective rates. These services can be covered through bundled payments for the complete service.

- continued on page 12

Transformation in Economic Models of Health Care continued from page 11

Louis-Joseph Auguste, MD, MPH, FACS, Chair/Board of Trustees, MSCQ & AMQC

However, emergency care is unpredictable as far as time and place and the patients may need to be treated outside of the network of specialists associated with the given medical home. Therefore, fee for service may not be completely barred as an option, but its use will be limited and reviews of the indications will always be necessary.

These services should above all be affordable for both the individuals and the country. Health care dollars should be used for patient care and not to fill the pockets of shareholders from far away lands or of greedy CEO and administrative staff. This health care system cannot afford to pay annual salaries as high as $27 million and severance packages as high as $1.5 billion, as has been reported. The country's health care cannot be left to private commercial insurers with an eye first for profit, even if it means depriving an individual of essential care. Medicare shows us that administrative cost can be reduced to 5% of the premium dollar, instead of the 20 to 25% incurred by most of the commercial plans. Thus, a universal single-payer system would seem to maximize the use of the health care dollars.

However, there is no utopia on earth and as the proverb says: "you can lead your horse to the water, but you cannot force him to drink." An improvement of the U.S. population health will imply a paradigm shift in its mentality. We recently had the opportunity to observe the failure by Mayor Michael Bloomberg to implement a limit on supersized soda drinks or the opposition to Michelle Obama who wanted to ban fast food from school cafeterias. Efforts to get Americans off the couch and exercise would have to compete with TV programming which manages to consume an average of four hours a day of an American's life. Thus, although value-based reimbursement should be geared towards outcome and results, failure to reach a target may be a failure on the part of the individual and not of the medical system.

Outcomes also can be linked to all the sociopolitical and economic changes occurring in the country. It takes a lot of political will to pass meaningful laws regarding the use of guns and other lethal weapons. As far as the drug epidemic, we just witnessed a giant effort spurred by the Surgeon General and supported by our legislators to curb the availability of medically prescribed narcotics. Meaningful changes can be achieved but it requires unbiased thinking and cooperation of all the willing stakeholders. ■

About the Author

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Online Media Campaign

"As we enter the toughest and deadliest phase of the virus, the Queens Chapter is poised to make a meaningful impact on the health and well-being of its society members and the general public.

Queens is diverse and multicultural, serving as one of the world's most linguistically diverse neighborhoods. Many challenges remain including health care disparities and language barriers which have challenged the ability of many health experts to communicate fact from fiction to the general public. We need to advocate on their behalf and provide key public health guidance on issues like the importance of vaccines.

Over the next few months, MSSNY's Queens Chapter will identify key issues/objectives and formalize plans to proactively communicate around them. We are finding ways to start a series of online media campaigns that can be shared across social media channels so that our community of Queens (and society at-large) can remain safe. Please let us know if you are interested in this initiative. We look forward to your participation."

Thank you,

Erik J. Blutinger, MD, MSC
Emergency Medicine Physician
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Website Specialist
QMS@QueensMedicalSociety.org

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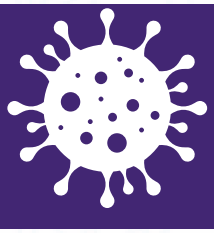

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