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Winter 2022

A publication of Arizona Academy of Family Physicians



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Family Physician FOCUS

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Edition 45



Sharyn Lancaster, MD,
President

“Follow the science...”

At the beginning of the pandemic, medical professionals turned to anecdotes from our colleagues on the East Coast and those in Europe for information. Back then, we yearned for *any* information- what is this virus? How serious is it? How do we treat it? Specifically, for me as a sports medicine physician, I was charged with developing a plan to allow for athletes to return to the empty campus at ASU and begin sports training. I looked to the German soccer league, *Bundesliga*, as they were the first major professional sports league to resume in-person activities, translating their German protocols into procedures that might work in the US. Then it was wait and see how it works- an observational study- and adjust failures to improve the process. These case reports were important in the early days as they helped us return to some elements of society that were previously in lockdown and offered treatment options, such as prone positioning for patients.

As we moved deeper into the pandemic, case control studies and cohort studies became available. These allowed us better quality evidence from which to counsel our patients. It was this data that led us to recommend optimizing vitamin D levels, along with the benefit of handwashing, mask-wearing, and social distancing. It was around this time that we began to say and hear “*Follow the science.*”

Our patients, family, friends, and colleagues asked us for advice during the pandemic, and we have said “follow the science” countless times. Every talking head on the news repeats it over and over. But when misleading studies are published by journals, others are retracted, and some not given a headline at all, how do we do this? And how do we best counsel our patients? Afterall, in medicine we are accustomed to high quality evidence like large randomized controlled trials and systematic reviews, which are still in their infancy with regard to COVID-19.

Sensationalist journalists often cherry pick a study to create a headline. Unfortunately, this erroneous headline is repeated by the media and on social media and usually without a deeper dive. My friends, I urge you to read more than the headline. We were all

trained on how to rigorously evaluate a medical study. Through our tremendous skill of critical analysis, WE are the best ones to counsel our patients to help lead through this pandemic.

Be sure to always read with a critical eye and ask yourself questions as you go. Notice the study design and use this to consider potential limitations. Also considering reading papers in a non-linear manner: they should not necessarily be read like a textbook. Critically evaluate the paper by examining the questions addressed. Are they descriptive, comparative, or analytical? Be sure to examine the evidence and the statistics, keeping in mind that, as Mark Twain said: “Facts are stubborn things, but statistics are pliable.” Evaluate the conclusions and determine if the data support the conclusions. Remember to look for limitations and biases, which should be but are not always reported in the discussion, including generalizing to a population that was not included in the study. This happened recently with a study out of Duke’s ABC Collaborative, where they suggested that “in schools with universal masking, test-to-stay is an effective strategy”. However, they did not study unmasked schools and so it is misleading to include that element. And do not forget to consider studies from journals outside your norm, especially including those in Europe and Israel who have a wealth of experience with COVID.

For a refresher on how to effectively choose and read a scientific article, there are many great resources online. One option: Subramanyam R. Art of reading a journal article: Methodically and effectively. *J Oral Maxillofac Pathol*. 2013;17(1):65-70. doi:10.4103/0973-029X.110733

In the end, our patients trust us more than a lettered agency or a social media report. It is our duty to evaluate the available evidence and present it to them in a way that is accessible and understandable. By doing this, I believe that we are the answer to misinformation epidemic that exists.



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Family Medicine Opportunities



Edward J. Schwager,
MD, FAAFP

On December 12, 2019, a cluster of patients in Wuhan, China began to experience shortness of breath and fevers. Under 4 weeks later Chinese scientists identified a novel coronavirus as the causative agent of the outbreak initially connected to the Huanan Seafood Wholesale Market in Wuhan. On January 5, 2020, the CDC's National Center for Immunization and Respiratory Diseases (NCIRD) activated a Center Level Response for novel pneumonia of unknown etiology. Within a few days the CDC published information about the novel coronavirus on its website. The first U.S. laboratory confirmed case of COVID-19 from Washington state occurred on January 20, 2020.¹ We are all familiar with subsequent public health efforts to limit the spread of this disease, vaccine development and administration, as well as the politicization of this crisis. Since January of 2020 more than 856,000 people in the U.S. have died from COVID.² This is 18 times higher than the estimated 48,000 deaths from influenza for the 2018-19 and 2019-20 flu seasons.^{3,4} Arizona's COVID-19 death toll exceeds 18,000.²

Like you, my personal and professional lives have been affected by COVID-19. Fortunately, none of my family members or circle of friends are among the tragic numbers of those who died. However, I have a grandchild, niece, nephew, grandnephews and a grandniece who have been infected. Their lives were upended as they recovered or adjusted schedules to care for others in their households. Our holiday gatherings, previously with participants in the upper teens, have been sparse. We have yet to travel by air. I am thankful for true crime podcasts easing the hours driving to and from Denver (I listen to the AFP podcasts too, but only when my wife has dozed off.) We now see the Arizona Theater Productions at home via a video link. It is a reasonable second choice but not as impactful as being there. International travel is on an indefinite hold. I am grateful to have a comfortable home and beautiful area to live in. Too many others have struggled with much more difficult circumstances than I.

Professional life has changed. Telehealth took off, and is a new skill for me, allowing patient care to continue and the business of medicine to thrive. When we are less concerned about the risk of in-person visits, telehealth will continue as a convenient patient and physician option for much of what we do. I find resident education more challenging with the pandemic. Precepting residents remotely is educationally more taxing than being face to face in clinic. During the shift of didactics to remote learning with everyone in separate locations, engagement of the learners is more variable. Some of our residents very much like being home rather than the classroom for these teaching sessions. To be determined is any difference in their education (and ultimately their ability to care for patients) or their well-being while being isolated instead of gathering.

I wrote in my fall 2020 column that to bring this pandemic to a crawl, we must continue to promote public health by encouraging mask wearing, social distancing and hand-sanitizing. COVID-19 vaccines were not available in the fall of 2020. Like the tobacco user whom we counsel at every visit the importance of being a non-smoker, we must encourage COVID-19 vaccinations and boosters for the vaccine hesitant. We still need to push our patients and our leaders to fully embrace all of the steps needed to bring back the health and well-being of our communities.

Be cautious and be well.

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Key CPT and Medicare Changes for Family Medicine in 2022

The 2022 updates don't include massive E/M coding changes like last year, but several changes are much-needed and relevant to family physicians.

KENT MOORE, EMILY HILL, and ERIN SOLIS
Fam Pract Manag. 2022 Jan-Feb;29(1):9-14. Author disclosures:
no relevant financial relationships.

Once again, the start of a new year brings changes to CPT coding, Medicare payment policy, and Medicare's Quality Payment Program (QPP). Some of this year's changes are much-needed, which will hopefully lessen the pain of adjusting to them. Here's what's most relevant to family physicians.

KEY POINTS

- CPT clarified aspects of last year's E/M coding changes, including the definition of a "unique" test, what "discussion" between physicians and patients means, and the difference between major and minor surgery.
- There are several telehealth-related changes this year, including a Medicare provision for ongoing coverage of audio-only mental health services under certain conditions.
- The Centers for Medicare & Medicaid Services has increased the rates it pays for chronic care management and for administering several vaccines.

CPT CHANGES

There are several noteworthy CPT changes this year, including some related to evaluation and management (E/M).

Office and other outpatient E/M services. Last year CPT made substantial changes to new and established patient E/M codes (99202-99215).¹ This year CPT clarified several aspects of those changes, including the following:²

- Specifying which activities do not count when time is used to determine the level of service: travel, teaching that is general and not limited to management of that specific patient, and time spent on other, separately reported services.
- Clarifying when to report a test that is considered but not selected after shared decision making: A test that is considered

but not performed counts as long as the consideration is documented. For example, the physician may explain to the patient that a diagnostic test the patient requested would have little benefit.

- Defining "analyzed" for reporting tests in the data column: "Analyzed" means using data as part of the medical decision making process. Tests that do not require an analysis still count if they are a factor in diagnosis, evaluation, or treatment.
- Clarifying the definition of a "unique" test: Multiple results of the same tests during an E/M service are considered one unique test. Tests with overlapping elements are not considered unique even if they have distinct CPT codes.
- Clarifying what is meant by "discussion" between physicians/other qualified health care professionals (QHPs) and patients: "Discussion" requires a direct, interactive exchange. Sending notes does not count.
- Clarifying who decides the difference between major and minor surgery: The classification of major and minor surgery is determined by the meaning of those terms when used by a trained clinician. It is not determined by payers' classifications of surgical packages.

Principal care management services. CPT added a new category of principal care management (PCM) codes (99424-99427) to the "Care Management Services" section. Unlike chronic care management and complex chronic care management, PCM focuses on medical or psychological needs caused by a single, complex chronic condition expected to last at least three months. PCM services include establishing, implementing, revising, or monitoring a care plan directed toward that single

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condition. PCM codes can be reported by different physicians or QHPs in the same calendar month. Clinical documentation should reflect coordination of care among the managing clinicians.

Codes 99424 and 99425 are for services personally provided by a physician or QHP. Codes 99426 and 99427 are for services provided by clinical staff under the direction of a physician or QHP. Codes 99424 and 99426 are for the first 30 minutes per calendar month. Codes 99425 and 99427 are add-on codes for each additional 30 minutes per calendar month. PCM services that require fewer than 30 minutes a month are not reported separately. You can only report code 99427 twice in a calendar month. If the treating physician or QHP personally performs any care management services but does not meet the 30-minute threshold, those services can be counted toward the required time for the clinical staff codes.

All PCM services require the following elements:

- One complex chronic condition expected to last at least three months that places the patient at significant risk of hospitalization, acute exacerbation or decompensation, functional decline, or death,
- The condition requires development, monitoring, or revision of the disease-specific care plan,
- The condition requires frequent adjustments in the medication regimen, or the management of the condition is unusually complex due to comorbidities,
- Ongoing communication and care coordination between relevant clinicians providing care.

Remote therapeutic monitoring and treatment. CPT added three new codes for remote therapeutic monitoring of the respiratory and musculoskeletal systems. The codes are for reviewing and monitoring data related to signs, symptoms, and therapeutic responses during a 30-day period. The monitoring can include objective, device-

generated data or subjective data provided by the patient. A physician or QHP must order the service, and the device must be a medical device as defined by the Food and Drug Administration (FDA). Do not report these codes with other physiologic monitoring services or if the monitoring is less than 16 days. Use code 98975 to report device setup and patient education. Use codes 98976 and 98977 to report supplying the device for scheduled recordings and/or programmed alert transmissions (98976 is for respiratory system monitoring, and 98977 is for musculoskeletal system monitoring).

CPT also added two new codes for treatment management services that stem from remote therapeutic monitoring. You can report these codes when a physician or QHP uses the results of remote therapeutic monitoring to manage the patient under a specific treatment plan. The codes require at least one interactive communication with the patient or caregiver. As with the monitoring codes, a physician or QHP must order the service, and the device must be a medical device as defined by the FDA. Code 98980 is for the first 20 minutes of service during a calendar month, and code 98981 is an add-on code for each additional 20 minutes. Do not report services of fewer than 20 minutes. You can report these services in addition to chronic care management, transitional care management, PCM, and behavioral health integration. Time spent on other separately reported services, including E/M services, cannot be counted toward the time of the remote therapeutic monitoring and treatment management services.

Vaccine and administration codes. CPT 2022 includes five new vaccine codes and nine new vaccine administration codes related to COVID-19. For administering a COVID-19 vaccine, report the vaccine product code with the corresponding immunization administration code.³ All COVID-19 vaccine codes are listed in the vaccine section of CPT and in a new Appendix Q.⁴ If more updates occur during the year, they can be found at <https://www.ama-assn.org/practice-management/cpt/category-i-vaccine-codes>.

Other new vaccine codes for 2022 include the following:

- 90671: Pneumococcal conjugate vaccine, 15-valent (PCV15), for intramuscular use,
- 90677: Pneumococcal conjugate vaccine, 20-valent (PCV20), for intramuscular use,
- 90626: Tick-borne encephalitis virus vaccine, inactivated; 0.25 mL dosage, for intramuscular use,
- 90627: Tick-borne encephalitis virus vaccine, inactivated; 0.5 mL dosage, for intramuscular use,
- 90759: Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, three-dose schedule, for intramuscular use.

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Other services. The list of reportable telehealth services continues to expand. CPT identifies codes that can be reported using telemedicine with a star symbol (★) and lists them in Appendix P. This year CPT has added code 99211 to the list and included patient- and caregiver-focused health risk assessment codes 96160 and 96161. Inpatient prolonged services codes 99356 and 99357 also join the list.

CPT has revised the guidelines for repair (closure) to specify that chemical cauterization, electrocauterization, or wound closure utilizing adhesive strips as the sole repair material are included in the appropriate E/M code. CPT also revised the definition of a simple repair to clarify that hemostasis and local or topical anesthesia are not reported separately.

MEDICARE PHYSICIAN FEE SCHEDULE CHANGES

The Centers for Medicare & Medicaid Services (CMS) was set to lower the 2022 conversion factor (i.e., the amount Medicare pays per relative value unit, or RVU) from \$34.89 to \$33.59, but Congress intervened in December with a one-year rate increase of 3%. The new conversion factor is \$34.6062, nearly the same as last year.

Telehealth. As the pandemic continues, CMS will retain all services temporarily added to the Medicare telehealth services list until the end of 2023. CMS will also implement telehealth mental health provisions enacted by the Consolidated Appropriations Act of 2021. This includes removing geographic restrictions and adding the patient's home as an eligible originating site for telehealth services for the diagnosis, evaluation, or treatment of a mental health disorder. This change extends beyond the pandemic. Telehealth services for mental health may be furnished in the patient's home if the physician or other clinician provided an item or service in person within the six months before the initial telehealth service, and within the 12 months before any subsequent telehealth service.

CMS has revised its definition of "interactive telecommunications system" to permit audio-only tele-mental health services provided to beneficiaries in their homes under certain conditions. Again, an in-person service must be furnished within six months of an initial audio-only mental health service and within 12 months of any subsequent audio-only mental health service. CMS will only cover this for physicians or providers who have the capacity to furnish two-way audio-video telehealth services but use audio-only because the beneficiary can't use, doesn't wish to use, or doesn't have access to two-way audio-video

technology. CMS will create a modifier to identify audio-only services furnished to patients in their homes.

Finally, CMS is permanently adopting payment for code G2252 (Brief communication technology-based service, e.g., virtual check-in, by a physician or other QHP who can report E/M services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion). The national (not geographically adjusted) 2022 Medicare payment allowance for this code was estimated at \$27.21 in the nonfacility (e.g., office) setting, though this could change with the conversion factor.

continued on page 14

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Vaccine administration. Effective Jan. 1, 2022, CMS will pay \$30 per dose for administering the influenza, pneumococcal, and hepatitis B vaccines. CMS will also maintain the current payment rate of \$40 per dose for administration of the COVID-19 vaccines through Dec. 31 of the year in which the COVID-19 public health emergency ends. After that, CMS will reduce the COVID-19 vaccine administration payment rate to match other Medicare Part B vaccines.

Chronic care management. CMS is increasing the RVUs for chronic care management codes, resulting in increased payment rates (see “2022 Medicare chronic care management payment updates”). For example, payment for code 99490 (Chronic care management, clinical staff, first 20 minutes) will increase about 50%. This also may change with the conversion factor.

2022 MEDICARE CHRONIC CARE MANAGEMENT PAYMENT UPDATES

CODE	BRIEF DESCRIPTION	2021 ALLOWANCE*	2022 ALLOWANCE*
99490	CCM, clinical staff, first 20 minutes	\$41.17	\$62.14
99439	CCM, clinical staff, each additional 20 minutes	\$35.68	\$47.03
99491	CCM, physician/QHP, first 30 minutes	\$82.35	\$83.64
99437	CCM, physician/QHP, each additional 30 minutes	(new for 2022)	\$59.45
99487	Complex CCM, clinical staff, first 60 minutes	\$91.77	\$130.33
99489	Complex CCM, clinical staff, each additional 30 minutes	\$43.97	\$68.52

*Nonfacility setting; does not reflect any geographic adjustments. 2022 rates shown are from the final rule; for updated rates, see the CMS Physician Fee Schedule Look-Up Tool at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup>

READ MORE IN *Fam Pract Manag.* 2022 Jan-Feb;29(1):9-14.
<https://www.aafp.org/fpm/2022/0100/p9.html>

At the Arizona Capitol, COVID-19 Mitigations Spark Partisan Debates

Susan Cannata, JD

For some, the opening day of the 2022 legislative session on January 10 was a celebration – a chance to reunite with friends and colleagues after almost two years of pandemic-driven doubt and physical separation. For others, it was a frightening and overcrowded event that threw caution to the wind and pointed to a long year ahead.

The divide between the two viewpoints was almost entirely defined by political party affiliation.

Republican leaders in the House and Senate have ended protocols they enacted last year to stop the spread of COVID-19 at the Capitol. Mask mandates and plexiglass desk dividers are gone, along with Zoom participation for legislators and members of the public. Legislators with health concerns may request permission to cast their votes for committee and floor sessions remotely from their office at the Capitol, but they cannot ask questions or explain their votes.

House Speaker Rusty Bowers (R-Mesa) said it was time to end remote participation because it degraded the quality of the legislative process. Last year, members of both parties voted while driving or juggling other tasks. One lawmaker even tried to text in his vote while flying an airplane for the National Guard. By requiring in-person participation at the Capitol, Bowers and Senate President Karen Fann (R-Prescott) say they hope the legislative process can return to what it was before the pandemic.

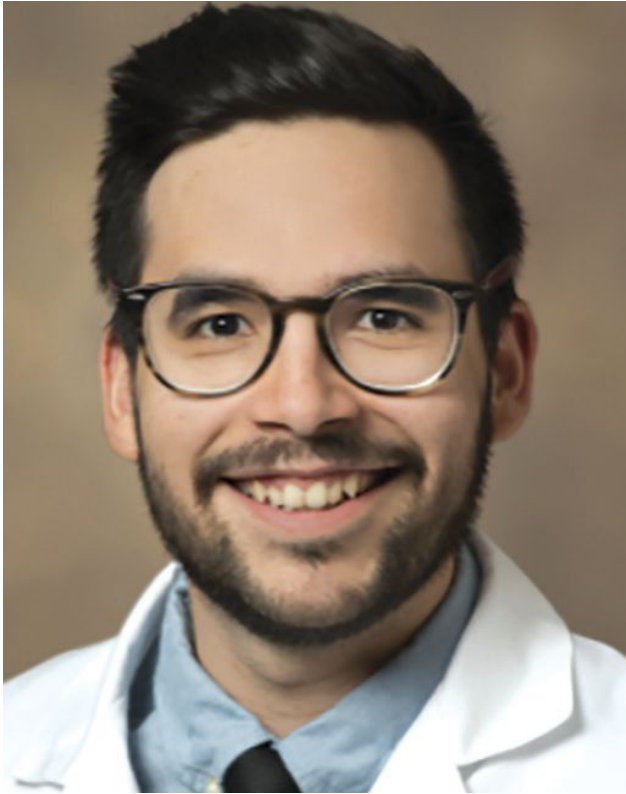
There was a time when Democratic lawmakers agreed with concerns about long-distance legislating: When Republicans adopted remote voting in 2020, Democrats argued that it would harm the process and was introduced just to ensure Republicans could vote even if they were sick. Now, though, Democrats say the technology for remote participation has proven to be successful, and the precautions are still necessary as COVID-19 case numbers climb around the state.

It didn't take long for COVID-19 to spread around the Capitol. Members of both political parties contracted the virus within the first week and isolated at home, as did some legislative staffers. There's on-site rapid testing for anyone who wants it, and House and Senate leaders provide excused absences for any lawmakers who are sick or choosing to remain at home. As the session advances, though, scheduling will get more complicated – especially for votes on controversial measures.

COVID-19 brought an abrupt end to the legislative session in 2020 and upended the process during the 2021 session. In 2022, it remains to be seen whether the spread of the virus will interrupt efforts to return to normal or just be a speed bump in an already divisive session.



AZAFP Awards Committee Names 2 Resident Award Winners!



Francisco Gomez, MD WINS Walter Brazie, MD AWARD

Francisco Gomez grew up near the Texas-Mexico border where he observed first-hand how racial, social and financial hardships impacted healthcare disparities. This experience served as his inspiration and motivation to pursue a career in medicine, specifically in the specialty of Family Medicine. After graduating from the University of Texas Health Science Center in San Antonio, Texas, he accepted a residency position at the University of Arizona - Alvernon Family Medicine Residency Program. After consistently gravitating into the role of educator and mentor, he has decided to pursue a career in academic medicine upon graduating from Residency this coming June. His passion for addressing issues related to social determinants of health, has led him into a partnership with Tucson Family Advocacy Program to create and a mobile app to assist patients in utilizing all the available city resources available to them. He is dedicated to inspire others to optimize the delivery of medical care, eliminate disparities, and give back to the community that they love. His hobbies include writing and recording music, hiking, rock climbing, listening to podcasts, watching documentaries, and traveling with his wife when able.

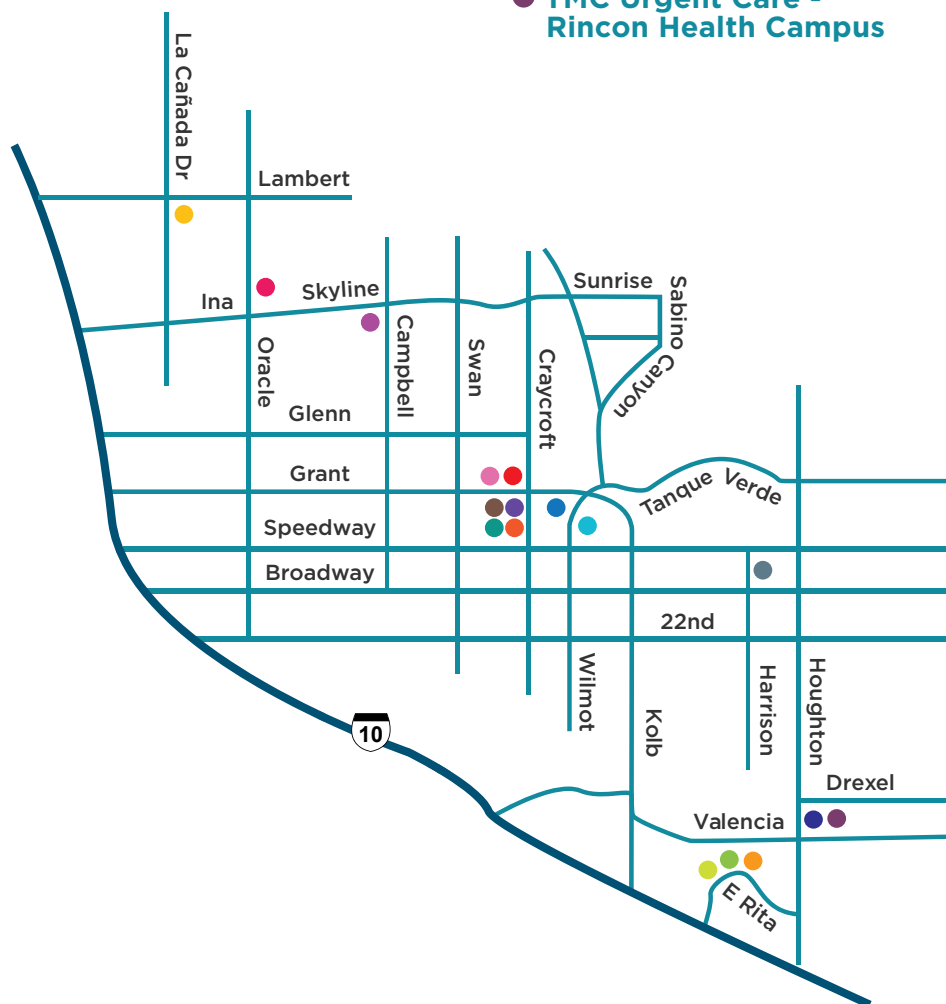


Monica Chaung, MD WINS James Grobe, MD AWARD

Monica Chaung is a Phoenix native. She graduated from the University of Arizona College of Medicine - Phoenix and completed her family medicine residency training at the HonorHealth Scottsdale Osborn Medical Center. She was involved in her residency program's Diversity, Equity and Inclusivity committee to bring awareness and understanding of health inequities experienced by different patient populations. In the face of the pandemic and in recognition of physician burnout, she organized wellness activities and served as a peer supporter for other residents. She is currently completing her geriatric medicine fellowship at HonorHealth as their inaugural fellow. Her quality improvement focus in fellowship is on reducing fall risk in geriatric patients. She is dedicated to giving back to her community and advocating for older adult care. Her hobbies include baking her favorite turtle brownies, moving into a yoga flow, and spending time with family and friends.

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Specialty: Family Medicine • Pediatrics

● TMCOne: Rita Road #180

Specialty: Family Medicine

● TMCOne Rita #100

Specialty: Family Medicine

● TMCOne: Rincon

Specialties: Family Medicine
Pediatrics • Gynecology

● TMC Urgent Care - Rincon Health Campus

CENTRAL

● TMCOne: Wyatt

Specialties: Internal Medicine
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● TMC Urgent Care - TMC Main Campus

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● TMCOne: Oro Valley Coming Soon

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COVID-19 Disease Outbreak Outlook Arizona and Pima County

Updated January 28, 2022

Created by Joe K. Gerald, MD, PhD (Associate Professor, Zuckerman College of Public Health, geraldj@email.arizona.edu) with assistance from Patrick Wightman, PhD from the UA Center for Population Health Sciences.

Disclaimer: This information represents my personal views and not those of The University of Arizona, the Zuckerman College of Public Health, or any other government entity. Any opinions, forecasts, or corresponding recommendations should be considered in conjunction with other corroborating and conflicting data. Past updates can be accessed at <https://publichealth.arizona.edu/news/2021/covid-19-forecast-model>.

For the week ending January 23rd, at least 122559 Arizonans were diagnosed with COVID-19, a 13% decrease from the 133806 cases reported the prior week (Figure 1). Last week's initial tally has been updated to 141895 (+8089, +6%) cases. *Omicron* peaked statewide about January 15th at 1967 cases per 100K residents per week. While reaching a peak is a welcomed, the risk of contracting *Omicron* remains extremely high as the ride down is likely to be slower than the ride up. It is too soon for institutions and/or individuals to safely relax their mitigation practices as the level of transmission is more important than the direction of change.

Cases are currently being diagnosed at a rate of 1684 cases per 100K residents per week. Rates remain highest among those 15 – 24 years and lowest among those ≥65 years, 2089 and 1031 cases per 100K residents, respectively (Figure 2a following page). Arizona's new case ranking has risen to 7th and, we are closing the gap with the nation's leaders: Alaska (2360), Washington (1907), Kentucky (1897), Oklahoma (1839), and West Virginia (1809). Hopefully, Team Arizona will be hitting on all 4 cylinders by March Madness!

According to the CDC, 40% of Arizona adults and 57% of its seniors have obtained a third dose booster. Fortunately, the primary 2-dose Pfizer sequence retains 70% protection against hospitalization from *Omicron*. The ADHS Vaccine Dashboard shows weekly doses delivered fell just shy of 125K doses. So, we continue to make slow, plodding progress. The CDC recommends everyone ≥12 years who received Pfizer primary sequence should receive a booster; ≥18 years if they received the Moderna primary sequence.

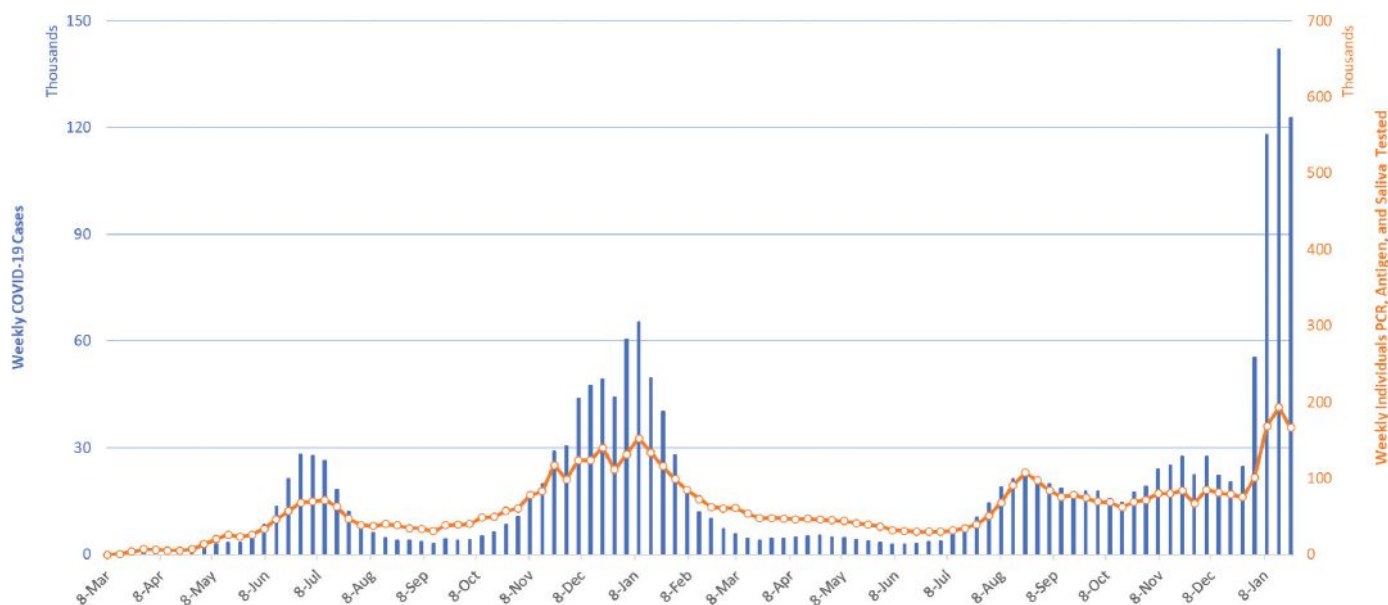


Figure 1. Weekly COVID-19 Cases in Arizona and Number of Individuals Undergoing COVID-19 Diagnostic Testing March 1, 2020 – January 23, 2022.

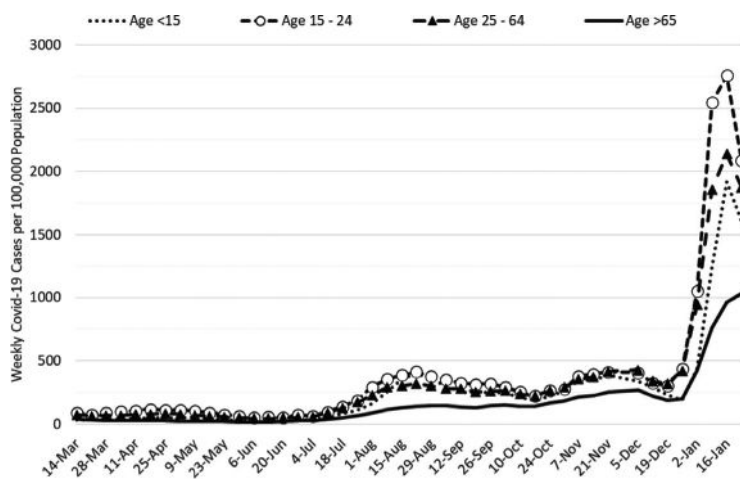


Figure 2a. COVID-19 Cases in Arizona by Age Group March 7, 2021 – January 23, 2022 (Data from week ending November 28 suppressed).

Figure 2a shows transmission among all age groups is decreasing except among those ≥ 65 years. Figure 2b shows that transmission among children is declining across all age groups. A quick shout-out to all of Arizona's K – 12 educators, staff, and administrators for taking one on the chin this month. Student and staff absenteeism should begin waning soon. February will still be a difficult month but at least there is a light at the end of the tunnel, and it's probably not the train.

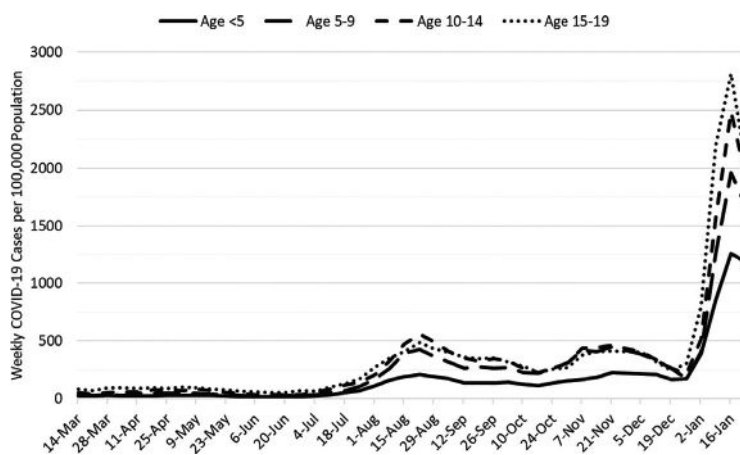


Figure 2b. COVID-19 Weekly Incidence in Arizona among children March 7, 2021 – January 23, 2022.

Test positivity declined for the first time in a while to 55% (Figure 3). Now that cases, testing, and positivity are all declining, the *Omicron* peak is all but certain. However, other jurisdictions have seen a follow-on “bounce” wave, smaller than the first, due to relaxing mitigation and perhaps the new more transmissible BA.2 *Omicron* variant. We should expect the ride down the backside of the peak to be bumpy.

As of January 27th, 3559 (41%) of Arizona's 8767 general ward beds were occupied by COVID-19 patients, a 4% increase from last week's 3410 occupied beds

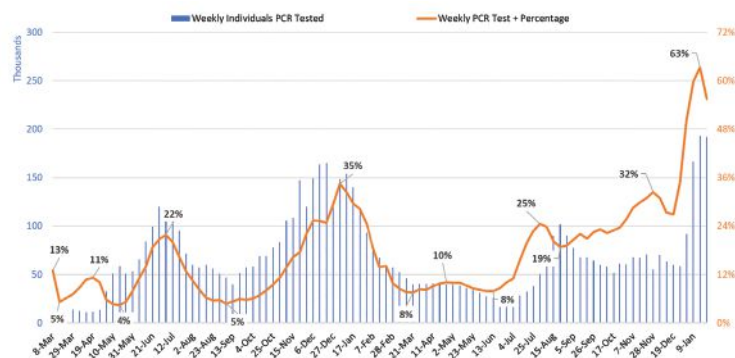


Figure 3. Weekly Number of Patients Undergoing Traditional Nasopharyngeal PCR Testing and Associated Percent Positivity March 1, 2020 – January 23, 2022.

(Figure 4 and Figure 5 Panel A). Another 405 (5%) beds remained available for use which is much lower than last week's 492 available beds. Six-hundred thirty-six (636, 39%) of Arizona's 1648 ICU beds were occupied by COVID-19 patients, a 7% increase from last week's 597 occupied beds (Figure 4 and Figure 5 Panel B). An additional 92 (6%) ICU beds remained available for use which is lower than last week's 127 beds.

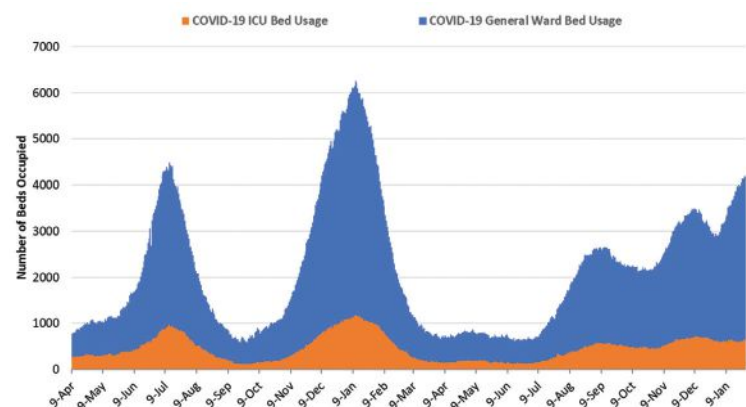


Figure 4. Arizona Daily COVID-19 General Ward and ICU Census April 9, 2020 – January 27, 2022.

While peak occupancy won't reach prior levels, we remain above 4000 combined occupancy for only the 3rd time. The overlapping *Delta* and *Omicron* waves have placed hospitals under greater strain than prior waves. We have now experienced 167 consecutive days with a combined occupancy >2000 patients whereas the summer 2020 and winter 2021 saw 57 and 98 days, respectively. We have now experienced 62 days with >3000 combined occupancy whereas the summer 2020 and winter 2021 waves saw 35 and 78 days, respectively. Just like Wile E Coyote, hospitals are getting crushed by a slow rolling steam roller. No end in sight.

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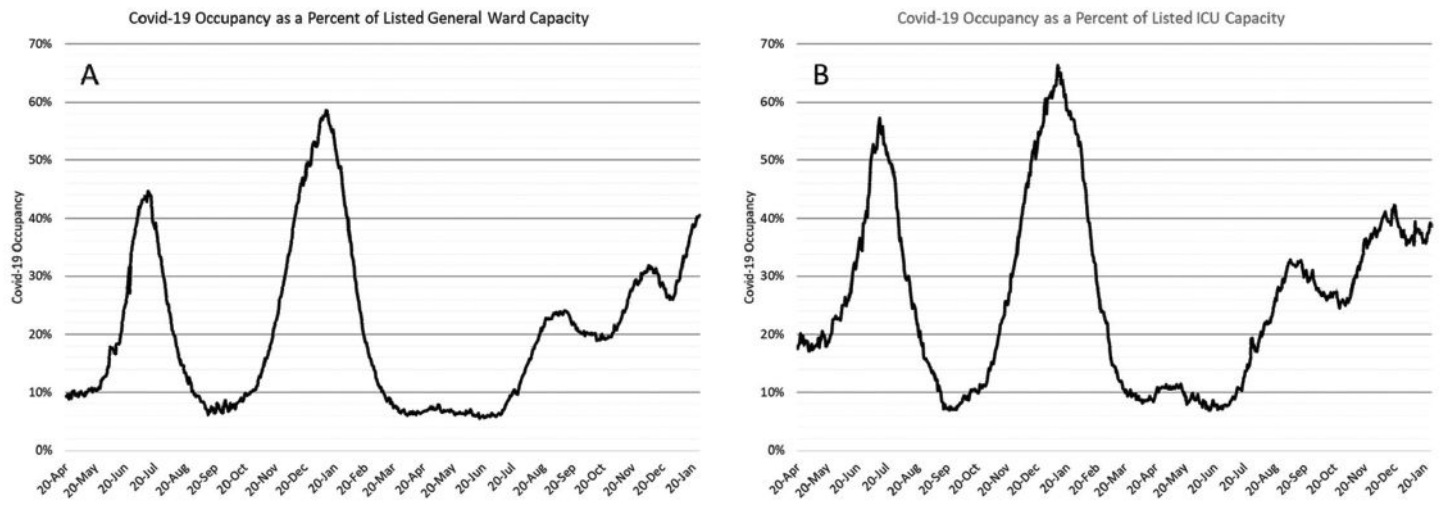


Figure 5. COVID-19 Occupancy as a Percent of Listed General Ward (A, left) and ICU (B, right) Capacity in Arizona April 20, 2020 – January 27, 2022.

Hospital occupancy remains far above seasonal levels with safety margins, as measured by available beds, remaining near historical lows (Figure 6). Hospitals should prepare for >30% ward occupancy and ICU occupancy through February.

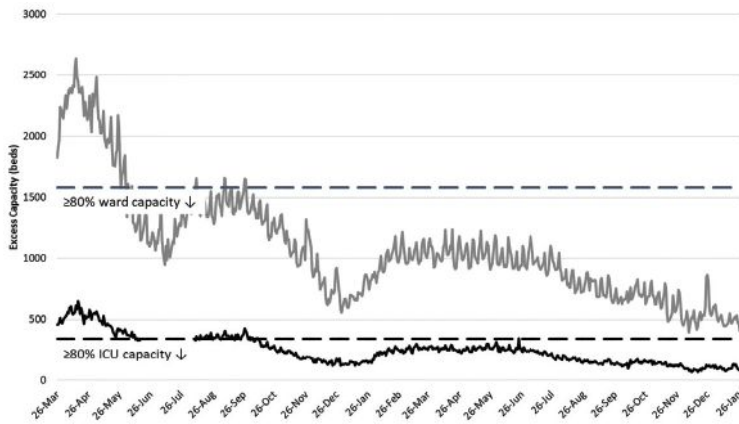


Figure 6. Observed Excess Non-Surge General Ward and ICU Capacity in Arizona March 26, 2020 – Jan 27, 2022.

Seasonal influenza cases in Arizona (blue line) has fizzled, at least as compared to the state's 5-year historical average (grey bars, Figure 7). COVID-19 mitigation efforts may have slowed influenza transmission. Hospitals should begin to get relief from fewer COVID-19 and fewer influenza cases over the coming weeks.

The week ending December 12th has now recorded 542 deaths to date. Hopefully, this will be the only week this happens during the *Delta* - *Omicron* waves (Figure 8a). At least 26001 Arizonans have lost their lives to COVID-19. A mortality report from the AzPHA indicates that official statistics undercount actual deaths.

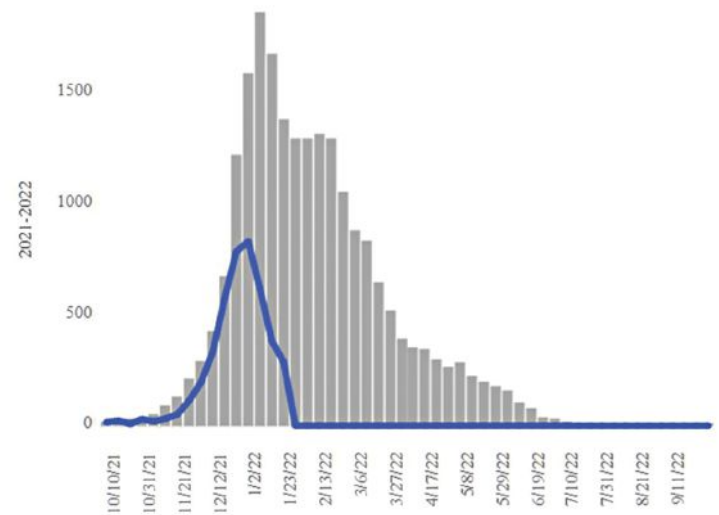


Figure 7. Arizona Influenza Cases in 2021 (blue) versus 5-Year Historical Average (grey)

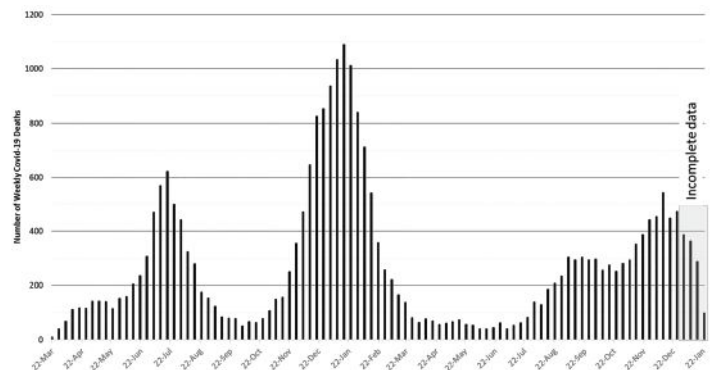


Figure 8a. Weekly Arizona COVID-19 Deaths March 16, 2020 – January 23, 2022.

Figure 8b shows age-specific case-fatality rates (CFR) by year. Crude CFR is subject to surveillance bias for both cases (large undercounting) and deaths (modest undercounting). The bias may differ by age. The impact of vaccination is most apparent for those >55 years whereas crude CFR was the same or a bit higher in 2021 than 2020 among working age adults.

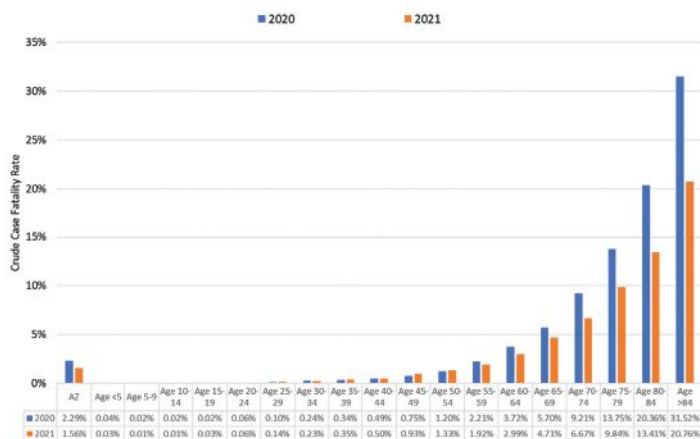


Figure 8b. COVID-19 Crude Case Fatality Rate by Age and Year

The age-standardized CFR has remained remarkably stable between 1.5 – 2.0% for over a year (Figure 8c). The CFR is standardized to a case age distribution the week of October 25, 2020.

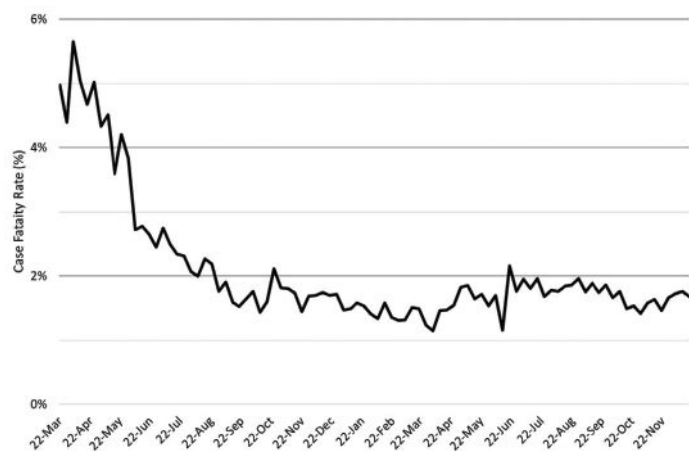


Figure 8c. COVID-19 Age-Standardized Case Fatality Rate March 22, 2020 – December 19, 2021 (October 25, 2020 Age Distribution).

The proportion of COVID-19 deaths among the elderly (≥60 years) and eldest, elderly (80 years) both fell in March 2021 following the targeted vaccination campaign (Figure 8d). However, deaths have since returned to pre-vaccine levels for those >60 years, but not among those >80 years. This suggests deaths shifter younger in the >60 demographic and away from those >80 years.

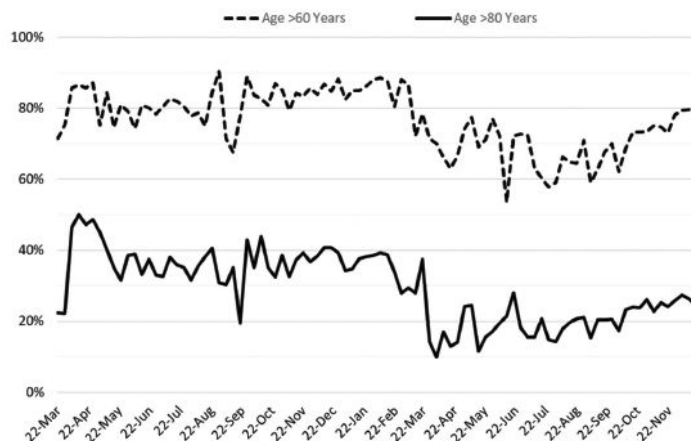


Figure 8d. Proportion of COVID-19 Deaths Attributable to Those >60 Years and >80 Years, March 22, 2020 – December 19, 2021.

Because I have the room, I thought I would throw in one more figure. Figure 8e shows the ratio of the daily COVID-19 ward and ICU census. Typically, when cases increase rapidly ward occupancy increases relative to ICU occupancy. This trend was considerably more pronounced with the *Omicron* wave likely due to its lower severity.

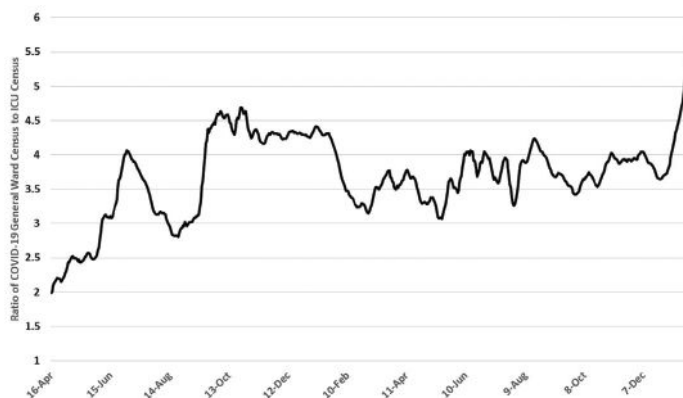


Figure 8e. Ratio of COVID-19 Daily General Ward Census to ICU Census April 16, 2021 – January 27, 2022.

Pima County

For the week ending January 23rd, 17055 Pima County residents were diagnosed with COVID-19, a 2% increase from the initial tally of 16669 cases last week (Figure 9). Depending on backfill, this week or last will likely be Pima County's peak. Transmission by age group is shown in Figure 10.

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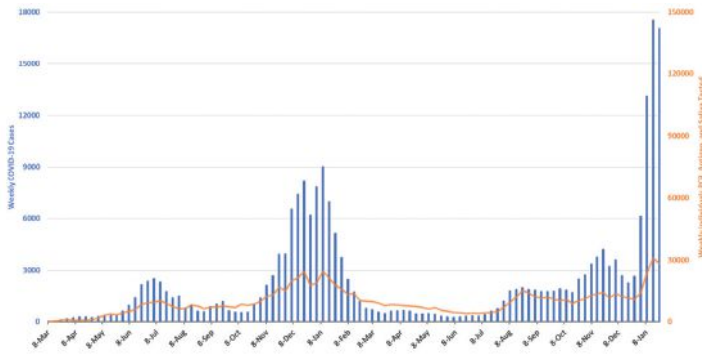


Figure 9. Weekly COVID-19 Cases in Pima County and Number of Individuals Undergoing COVID-19 Diagnostic Testing March 1, 2020 - January 23, 2022.

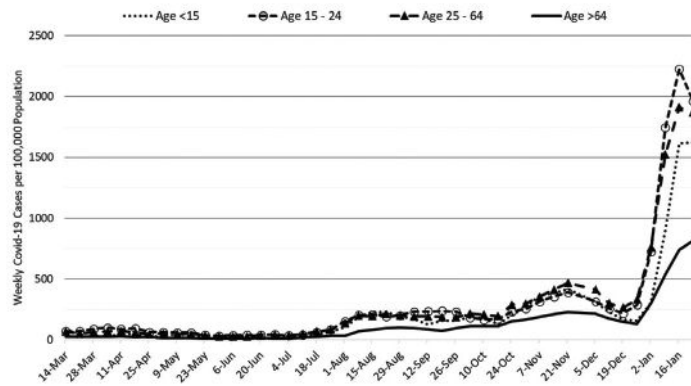


Figure 10. COVID-19 Weekly Incidence in Pima County by Age Group January 10, 2021 versus January 23, 2022.

Summary:

- Arizona continues to experience historic levels of community transmission attributable to the dominant *Omicron* variant. Test positivity is insanely high reminding us that test capacity, accessibility, and/or uptake is wholly inadequate. Arizona, like much of the United States, is in the midst of another large pandemic wave. Transmission (cases) has peaked but risk of infection remains high.
 - As of January 23rd, new cases were being diagnosed at a rate of 1694 cases per 100K residents per week. Rates peaked last week at ~1967 cases per 100K residents week, somewhat lower than some other states, perhaps due to less testing.
 - Even if Arizona is moving down the backside of the wave, it is still important that all adults who previously completed the 2-dose primary sequence to obtain a booster, particularly those 50+ years of age.

- The risk of Omicron infection will remain extremely high for many weeks. Remember, the CDC defines high community transmission as levels >100 cases per 100K residents per week. We're a far cry from that!

- COVID-19 hospital occupancy in the wards continues to increase but should moderate soon. Hospitals will be burdened by >30% occupancy in general wards and in the ICU for several weeks yet. Access to care continues to be restricted by both COVID-19 occupancy and staff shortages owing to infections among healthcare workers. Friendly PSA – still too early to chew gum and walk or do anything really after saying, “Hold my beer and watch this!”
- Weekly COVID-19 deaths likely peaked at 542 deaths the week ending December 12th. However, weekly totals in the upper-300s, mid-400s are likely for several more weeks. So far, at least 26001 Arizonans have lost their lives to COVID-19.

Appendix

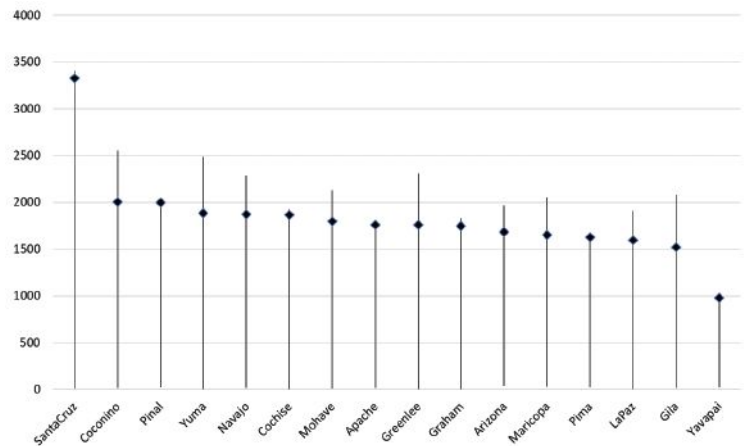


Figure 1A. Minimum, Maximum and Current COVID-19 Cases Rates per 100K Residents per Week by County April 1, 2020 - January 23, 2022.

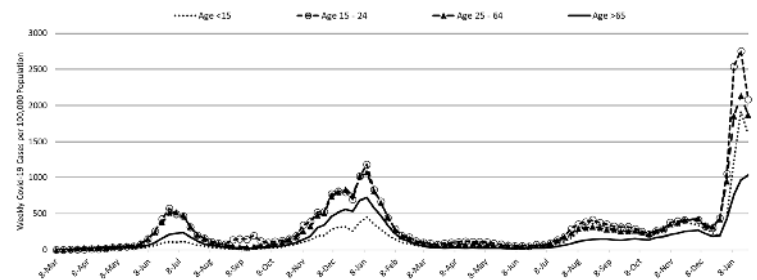


Figure 2A. COVID-19 Cases in Arizona by Age Group March 1, 2020 - January 16, 2022.



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