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AMCNO Co-Sponsors Quality Improvement Program

AMCNO SPONSORS THIRD-PARTY PAYER SEMINAR – SEE PAGE 12 FOR DETAILS

In June, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) co-sponsored a free kick-off quality improvement event presented by the American Medical Association (AMA), Johns Hopkins University, and the Health Services Advisory Group (HSAG)—which is the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Ohio, as well as Arizona, California, Florida and the U.S. Virgin Islands.

The AMA has been working with the Johns Hopkins Medicine (JHM) Armstrong Institute for Patient Safety and Quality and the Johns Hopkins Center (JHC) to Eliminate Cardiovascular Health Disparities to improve care for patients by developing and spreading a model for better detection and management of high blood pressure (BP), both in the clinic and in the community. To accomplish this goal, the AMA and JHC developed a quality improvement program focused on patients with hypertension. Participating in this program can help ambulatory practices engage care teams and patients in efforts to improve BP control. The HSAG has partnered with the AMA-JHM, because part of their 11th statement of work is to improve cardiac health and reduce cardiac healthcare disparities.

Under the banner of "Improving Health Outcomes: Blood Pressure" (IHO:BP), the program is designed to educate primary care teams in the QIN-QIO areas on implementing an evidence-based BP control regimen in their practices and health centers.

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Ohio Supreme Court and Eighth District Court of Appeals Trade Ability of Defendants to Immediately Appeal Rulings Requiring Production of Privileged Materials

AMCNO Files Amicus Brief in Case

By Martin T. Galvin and Catherine Sturik, Reminger Co., LPA

Quality assurance and peer review processes are valuable tools for the healthcare industry, particularly for hospitals and physicians. Internal investigations into problematic situations are a common method to evaluate procedures and performance, improve the quality of care, and investigate a potential lawsuit. In most circumstances, the quality assurance, peer review, or investigative efforts have been considered to be "privileged"—that is, the other party in a lawsuit is not entitled to documentation or results related to these efforts. This privilege is reflected in Ohio's statutory scheme, specifically R.C. 2305.25(D).

However, the application of quality assurance and peer review privileges are highly contested in most major medical malpractice litigation. Parties wishing to impose liability on physicians

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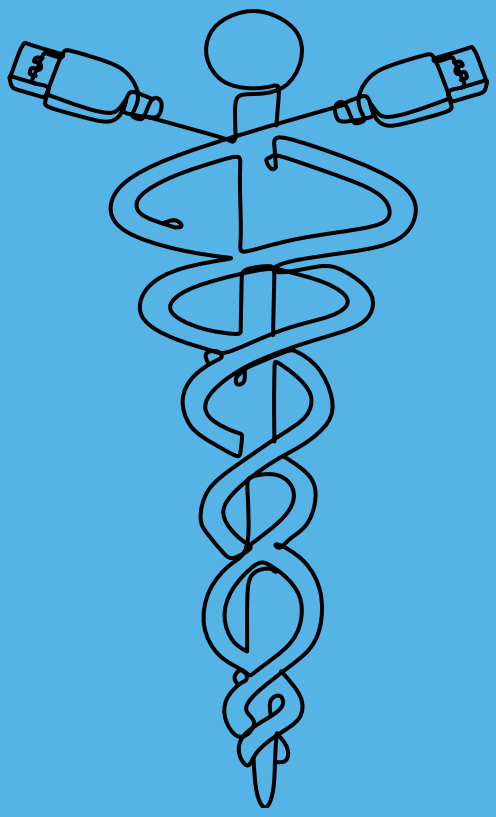

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AMCNO ACTIVITIES

AMCNO Co-Sponsors Quality Improvement Program

(Continued from page 1)

Physicians and nurses attended the kick-off event at the AMCNO offices and were introduced to evidence-based best practices to improve BP control of their patients. During the four-hour immersion, participants learned about the core elements, key tools, resources, and case studies that highlight successful implementation of best practices. Physicians also received continuing education credit for the session.

The event began with an introduction by Bonnie Hollopeter, LPN, DPHQ, physician office lead, HSAG – followed by presentations by Vikas Bhala, MPH, MBA, improvement advisor, Improving Health Outcomes, AMA; Michael Rakotz, MD, director, chronic disease prevention, AMA; and Lisa Lubornski, PhD, assistant professor, Johns Hopkins Armstrong Institute for Patient Safety and Quality.

This event, one of the first in the area, served as an introductory session to a curriculum for the IHO:BP program. The program's remaining curriculum is web-based and takes place over an 8-month period in two phases. Each month, providers will access an online module containing a pre-recorded podcast (no more than 30 minutes long) and a webinar to virtually convene and share their experiences. Topics include addressing staff and patient engagement, local culture and contextual factors.

The events provide an opportunity for providers participating in HSAG's cardiac health improvement initiatives to see firsthand how QIN-QIOs collaborate with high-profile, influential healthcare partners to improve care at the community level.

HSAG has received encouraging feedback from participants. Some providers plan to retrain their staff based on the best practices they learned during the kick-off, while others will take additional steps to identify patients who have the greatest need for BP control support.

The partnership between HSAG, JHM and AMA began during a brainstorming session at a 2014 Centers for Medicare & Medicaid Services' conference. JHM and AMA contacted HSAG in early 2015 to discuss opportunities for collaboration. The three organizations have conducted rapid-cycle improvements as they transition the IHO:BP event from one state to another, making the necessary refinements. This joint improvement process has reinforced the partnership between the organizations by encouraging collaboration, revealing common strengths and highlighting their shared mission.

The kick-off event at the AMCNO offices was featured in a national publication, and we were pleased to co-sponsor this kick-off event and to be one of the first organizations to host it. ■

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Ohio Supreme Court and Eighth District Court of Appeals Trade Ability of Defendants to Immediately Appeal Rulings Requiring Production of Privileged Materials *(Continued from page 1)*

and medical institutions often look for ways to skirt these privileges. A protection afforded to defendants when this happens is that any decision ordering production of privileged materials, including peer review and quality assurance documents, is immediately appealable to a court of appeals.

A recent Eighth District Court of Appeals decision, *Burnham v. Cleveland Clinic,* recently evaluated the scope of an appellate court's review of trial court decisions compelling production of privileged information.

Unfortunately, the *Burnham* decision creates uncertainty and poses a threat to the scope of privileged documents in the medical malpractice field.

While the *Burnham* decision is currently pending on appeal to the Ohio Supreme Court, it is important that healthcare institutions and medical organizations are aware of the implications of the *Burnham* decision and how it affects confidentiality of privileged information.

Burnham v. The Cleveland Clinic

The *Burnham* case involved an individual who slipped and fell at The Cleveland Clinic ("CCF"). In the discovery process, counsel for the injured individual requested CCF to produce a list of witnesses, witness statements, and the "internal incident report" created for the plaintiff's fall. CCF objected to producing the incident report, asserting it was protected by the attorney-client privilege. Because the incident report was to aid its risk management and law departments in the investigation of a potential lawsuit, CCF argued it was privileged attorney "work product" and not discoverable by the other party.

After the parties briefed the issue and the trial court inspected the incident report, the trial court determined the incident report was not privileged, and ordered its production. CCF appealed this decision to the Eighth District (Cuyahoga County) Court of Appeals.

"Final Appealable Order"

In order for an appellate court to review a trial court's decision, the decision must be a "final appealable order" pursuant to R.C. § 2505.02. For a long period of time, there has been well-established Ohio law that states trial court orders requiring production of arguably privileged documents are "final and appealable." Thus, appellate courts have traditionally reviewed trial court decisions on the discovery of privileged information—*even if the trial court case had not yet concluded in its entirety.*

However, despite the longstanding Ohio precedent, the *Burnham* court ultimately found the trial court's decision permitting the discovery of the incident report was not automatically a "final appealable order."

The Court read R.C. § 2505.02 to require the party challenging the trial court's order to "affirmatively establish immediate appeal is necessary to afford a meaningful and effective remedy." According to the Eighth District, if the appellant fails to establish they would not have an effective remedy after the trial court renders a final judgment on the entire case, there is no final appealable order, and the Court does not need to review the trial court's decision on the merits.

CCF argued it did not have an adequate remedy because once the incident report was produced, "the bell would have rung," and the disclosed sensitive material would be irreversibly put into the public realm. The Court rejected this argument.

Interestingly, the *Burnham* court heavily relied on an Ohio Supreme Court case, *Smith v. Chen,* in support of its position that appellants must establish jurisdiction at the appellate level. However, in the *Smith* decision, the Ohio Supreme Court specifically noted its decision was not to "make an appeal from an order compelling disclosure of privileged material more difficult to maintain."

Despite this language, the *Burnham* court nonetheless set a standard that makes an appeal from an order disclosing privileged information much more difficult to maintain.

Implications of the *Burnham* Decision

The *Burnham* decision brings confusion and uncertainty to an area of law where previously none existed.

The newfound burdens on defendants to establish the appellate court's jurisdiction are a significant concern after the *Burnham* decision. Should parties wish to appeal a discovery order to the appellate level, the parties now have to prosecute "an appeal within an appeal." That is, the appellant must not only present law, facts, and the assignment of errors in support of the privileged argument, but will also have to separately brief and argue the court's jurisdiction within its brief.

Such an onerous approach is not contemplated by the Ohio Rules of Appellate Procedure. It has never been the case that an appellant must proactively brief jurisdiction in every appeal involving production of privileged information.

Litigants' ability to protect privileged information, including peer review and quality assurance matters, is now in jeopardy. A privilege cannot be retrieved once pierced. Litigants' protected information might be forced to be disclosed, and once released—can never be confidential again. It is critical that the right to immediate appeal of these rulings be preserved.

What's Next?

The *Burnham* decision is currently on appeal to the Ohio Supreme Court. Before the issues of the appellate decision are heard on the merits, the Ohio Supreme Court must first decide whether to hear the case. The Court hears these cases that it finds to be "of public or great general interest."

The Academy of Medicine of Cleveland & Northern Ohio ("AMCNO") filed a brief to support the Ohio Supreme Court's jurisdiction. The Ohio Hospital Association and the Ohio State Medical Association also filed supporting briefs.

AMCNO cited significant policy concerns, including the public policy in support of quality assurance and peer review privileges, the interest of fair regulation of discovery, and promoting predictability in the law governing privileged documents.

The Ohio Supreme Court has not yet determined whether it will exercise its jurisdiction and subsequently consider the case on its merits. ■

AMCNO LEGISLATIVE UPDATE

Update on Budget Initiatives

During a meeting with representatives from regional and state medical and healthcare-related associations, including the AMCNO, Office of Health Transformation Director Greg Moody indicated that the administration will seek authority to establish Medicaid health savings accounts under a budget directive, noting that implementing the proposal is contingent upon federal approval.

The budget bill finalized in June requires the Medicaid director to seek a federal waiver mandating that all non-disabled adult Medicaid recipients enroll in a health savings account and pay in 2% of their family income, up to $99 per year. Ohio Medicaid, under the budget, must contribute an additional $1,000 annually to each individual's account, and health plans are prohibited from purchasing services for that person until the health savings account is exhausted.

Director Moody noted that setting various program requirements in statute could limit the state's response if provisions meet federal opposition and that the state could pursue additional legislation to allow for greater flexibility if waiver changes aren't approved. Director Moody also mentioned that the federal government hasn't yet approved cost sharing below 100% of poverty, which was mandated in the budget bill. He stated that the administration is expected to submit a waiver after collecting public input on the proposed Medicaid program changes. More information on this issue will be provided to AMCNO members in the future.

BWC Final Budget Creates Health Services Providers Cost Estimate Study Committee

In June, a provision was added to the BWC budget (HB 52) which creates the Health Services Price Disclosure Study Committee. Under this provision, the Office of Health Transformation is directed to establish the Health Services Price Disclosure Study Committee, and requires the committee to study the impact and feasibility of requiring health services providers to provide cost estimates. The study committee findings are to be included in a report to the governor and leadership of the Ohio House and Senate. If implemented, health services providers would be asked to give, upon request, a good-faith estimate for all non-emergency services. The effective date of this requirement is January 1, 2017, and requires the director of Medicaid to adopt rules to carry out the requirements under this provision that cover (1) how a cost estimate is to be provided to a consumer, and (2) the definition of "emergency products, services and procedures."

The Study Committee is also required to provide a second report which would give recommendations on how all health plan issuers can provide comparison prices from the health services providers to their own enrollees for comparison purposes. This second report is also required to contain recommendations on required cost information disclosure for health plans offered through the healthcare exchange for consumer comparison purposes.

Depending on the reports and recommendations, licensed, accredited, or certified providers of medical services could realize an increase in administrative costs to provide the cost information beginning January 1, 2017. The AMCNO will be monitoring this issue very closely.

Department of Health and Human Services Announces Steps to Address Opioid Crisis

Combating opioid abuse, dependence, and overdose is a priority for the Department of Health & Human Services, and their opioid initiative focuses on three targeted areas: informing opioid prescribing practices, increasing the use of naloxone (a drug that reverses the deadly respiratory effects of opioid drug overdose), and expanding the use of medication-assisted treatment to treat opioid use disorder.

The Health Resources and Services Administration (HRSA) plans to make $100 million in new funding available to approximately 300 Community Health Centers to expand services for those with substance use disorders, including medication-assisted treatment for opioid use disorder. Second, the Substance Abuse and Mental Health Services Administration (SAMHSA) is awarding $11 million to 11 states to expand and enhance medication-assisted treatment services. These funds will enable state treatment service systems to more effectively address the needs of people with opioid use disorders. The grants promote comprehensive, coordinated, and evidence-based, medication-assisted treatment and recovery support services.

The Centers for Medicare & Medicaid Services (CMS) will be releasing guidance to help states implement comprehensive, evidence-based service delivery approaches to substance use disorder treatment. It is estimated that 12% of all Medicaid beneficiaries ages 18-64 and 15% of uninsured individuals who could be eligible for Medicaid coverage have substance use disorder. Medicaid pays one out of every five dollars for substance use disorder treatment. CMS is establishing a new Medicaid demonstration initiative to states seeking to undertake significant improvements in the delivery of care to beneficiaries with substance use disorder.

Ohio has not yet determined whether or not they will take advantage of the demonstration project initiative. However, the state legislature has already passed legislation (HB 4) to address addiction issues and expand treatment services, such as increasing availability of an opiate overdose antidote (For more information on HB 4 see page 7.)

Ohio Human Trafficking Task Force Releases Report

The Ohio Human Trafficking Task Force recently released a report outlining their strategic priorities. Gov. John Kasich created the Task Force in 2012 to improve the state's response to the crime of human trafficking and to enhance efforts to work with victim service providers, law enforcement and the community to respond to trafficking in Ohio.

Key recommendations that have been implemented to date:

Partnered with a network of service providers to identify and treat exploited children and youth; started a statewide public awareness campaign—created a screening tool to be used in Ohio's mental health and correctional facilities—and trained agencies that come into contact with victims.

Priorities for the coming year include collecting reliable human trafficking data and making it available to the public, monitoring and adapting use of the screening tool, working

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to find prevention strategies to reach at-risk children and youth, and partnering with law enforcement to support interventions. In addition, there are plans to incorporate human trafficking training into continuing education learning for licensed professionals. All state boards (including the State Medical Board of Ohio) will be petitioned to incorporate human trafficking curriculum into their educational mandatory learning for all licensees. Discussions are underway at the SMBO regarding this issue, and the AMCNO will continue to monitor this discussion and provide information to our membership. (To view an article on the subject of human trafficking see page 8.)

State Medical Board of Ohio Update

Interstate Medical License Compact

Recently, the State Medical Board of Ohio (SMBO) sent information to all physician licensees regarding their position on joining the Interstate Medical License Compact. State medical boards across the country are joining the compact in the belief that it would allow a streamlined process for licensing. Under the current structure, there is no legal reciprocity for licensure, which means physicians who want to be licensed in other states must prepare for an extensive review process, depending on which states he/she applies in. As of June 2015, the model "Compact" legislation has been enacted by nine states: Alabama, Idaho, Minnesota, Montana, Nevada, South Dakota, Utah, West Virginia, and Wyoming. It has also been introduced in ten other state legislatures this year.

When a state joins a compact, a physician candidate applies for a medical license in his or her state of residence and provides the usual information—which would include proof of medical school graduation, residency training, a criminal background check, etc. After a physician obtains a medical license in an interstate compact state, he or she can apply for eligibility for an expedited license in other member states. Additionally, only physicians with perfect medical records are eligible to expedite the process. Such physicians must be board certified with no history of discipline, no history with the Drug Enforcement Administration (DEA), and no criminal history. If a physician qualifies, he or she needs only to obtain an eligibility certificate, then register for and pay the individual state license fee.

The compact would make it easier for physicians to take jobs in other states and the process would take less time to complete. Several medical associations, including the American Medical Association, support the interstate compact model and are working with the Federation of State Medical Boards on the process. The SMBO has chosen not to participate in the interstate compact, citing issues with confidentiality of complaints and ongoing investigations as well as concerns about how the compact will coincide with independent licensure requirements unique to the State of Ohio. To view the SMBO position on this issue visit their website at www.med.ohio.gov.

The AMCNO is still reviewing this issue—AMCNO members are welcome to send their comments about this issue to the AMCNO staff at ebiddlestone@amcno.org. For more detailed information about the compact, visit the FSMB website at www.licenseportability.org.

AMCNO and Other Medical Associations Voice Concern about One-Bite Rule Changes

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and eight other medical associations have sent a joint letter to the State Medical Board of Ohio (SMBO) regarding the medical board's proposed changes to Ohio's "one-bite" rule, which outlines how the SMBO deals with impaired physicians. The current rule allows impaired physicians and other licensed healthcare professionals who complete treatment and aftercare at a medical board-approved provider to remain in the private sector for monitoring, as long as their acts did not result in a criminal conviction or put patients or others at risk. However, the SMBO's suggested changes threaten the anonymity of the one-bite rule and could result in physicians who want help to actually avoid seeking treatment for fear of being publicly exposed.

In addition to voicing concerns about changes to the rule, the medical associations want the SMBO to alter the manner in which they screen physicians who have received treatment for mental health issues. Although other state regulatory boards have removed questions regarding treatment for mental health issues from their licensure applications, Ohio continues to ask these questions and then actively investigates these matters. The AMCNO and the other medical groups have suggested that the state licensure application be aimed at evaluating impairment rather than diagnosis or a history of treatment and to ensure uniformity in the screening of physical health and mental health diagnoses.

James Coviello, MD, AMCNO Immediate Past President spends a moment with Rep. Antonio at the AMCNO offices

The eight other medical associations that signed the letter (in addition to the AMCNO) were: the Ohio State Medical Association, Ohio Osteopathic Association, Ohio Psychiatric Physicians Association, Columbus Medical Association, Ohio Academy of Family Physicians, Ohio Foot and Ankle Medical Association, American College of Emergency Physicians – Ohio Chapter, and the Ohio Society of Addiction Medicine.

AMCNO Physician Leadership Provides Input to Legislators

During the summer months, AMCNO physician leadership met with legislators to review legislation under review at the Statehouse.

During a meeting with Rep. Nickie Antonio (D-Lakewood), AMCNO leadership outlined our concerns with HB 216—a bill that would change the practice of Advanced Practice Registered Nurses (APRNs). We outlined how the bill would eliminate the requirement that an APRN collaborate with a physician, giving an APRN complete independent practice authority with no collaborative agreement with a physician, eliminate the APRN/physician developed drug formulary for APNs with prescriptive authority, eliminate the requirement that CRNAs work under the direct supervision of a physician and provides for new prescriptive authority for CRNAs. The bill would also allow APNs to prescribe Schedule II narcotics in any setting except retail

convenience clinics. Finally, we noted that the bill also includes a provision that establishes a general scope of practice that would permit APNs to order and interpret diagnostic tests or procedures and diagnose medical conditions and diseases.

Rep. Antonio was informed that the AMCNO and many other medical associations across the state are concerned about certain aspects of HB 216. While the AMCNO values the professional abilities of APRNs, we believe HB 216 threatens the reliable assurance of safe and appropriate patient care at all times because the bill threatens to fundamentally change how physicians and APRNs collaborate.

These same concerns were also discussed with Rep. Dorothy Pelanda (R-Marysville), the sponsor of HB 216, during a recent interested party meeting. The parties involved in the meeting included the AMCNO and other medical associations from across the state. The medical associations in attendance noted that there are many facets of the bill that the medical community does not support at this time. Discussions will continue as the testimony on the bill starts when the legislature reconvenes in September.

Other bills discussed with legislators included HB 169—a bill that would expand the scope of practice for physical therapists. AMCNO representatives outlined our concerns with this bill as well, noting that we are especially concerned with the additional practice privileges that may be extended to physical therapists to "determine [medical] diagnoses in order to treat." It is our belief that the diagnosis of medical conditions should be performed by appropriately trained physicians or those mid-level providers, such as nurse practitioners or physician assistants, who are acting under the authority of a physician. The AMCNO opposes this bill and we plan to continue to make our position known on this legislation.

AMCNO representatives also provided our input on several bills that have been introduced by Rep. Robert Sprague (R-Findlay)—HB 248, HB 249 and HB 250. HB 248 would require insurers to cover abuse-deterrent drugs, and the AMCNO supports this bill. HB 249—drug overdoses—is a bill similar to the Good Samaritan legislation that was under review in the last General Assembly. It would provide immunity for certain drug users seeking emergency help for an overdose — the AMCNO supports HB 249 as well. The AMCNO does have concerns with HB 250—which would create prior authorization requirements when Medicaid patients are prescribed opioids greater than a 10-day supply for acute pain, greater than 80 morphine equivalent dose (MED) for chronic pain, or greater than a 72-hour supply if prescribed from an emergency setting. The AMCNO believes that this legislation would increase the burden on physicians and their practice, and we oppose this legislation at this time. ■

House Bill 4 – Expanding Access to Naloxone in Ohio

By Joan Papp, MD FACEP

Background

Ohio is in the midst of an opioid epidemic, with nearly six Ohioans dying of a drug overdose every day. Drug overdose has become the leading cause of injury death both in Ohio and across the nation since 2007– surpassing deaths from motor vehicle crashes for the first time on record. The Ohio Department of Health has reported that almost 75% of those deaths involve opioids such as heroin or prescription painkillers. As physicians, it is vital that we engage our patients in conversations about addressing their substance use disorder with safer prescribing of opioid pain medications, treatment for substance use disorder and overdose prevention and education. One additional tool that we have is a drug that we have been using for years in the hospital—naloxone.

Naloxone has traditionally only been available to patients when administered to them by a paramedic or a physician in the hospital by injection. Over the past several years, programs across the country have been providing patients access to this life-saving drug to use at home as a nasal spray or an auto injector to rescue an individual experiencing an overdose. In Ohio, Project DAWN (Deaths Avoided With Naloxone) provides this service. Since 2012, Project DAWN has been providing overdose education and naloxone overdose prevention kits in over 25 counties in Ohio at more than 50 locations statewide.

Naloxone Access

While Project DAWN has greatly expanded access to naloxone to at-risk individuals since 2012, several barriers continue to limit access. In 2013, Ohio first passed legislation to increase access to naloxone by allowing police to carry and administer naloxone, as well as family and friends of individuals who are at-risk for overdose. This was the initial step in improving access to the antidote.

This past July, Ohio took the next step in fighting this epidemic, allowing even greater access to naloxone. On July 17, Governor Kasich signed House Bill 4 into law, allowing naloxone to be made available by trained individuals and pharmacists authorized by a physician under a standing order protocol to dispense naloxone to individuals who are either at personal risk for opioid overdose or who may be in a position to rescue someone who is having an overdose. In practice, this means that any person can obtain naloxone without seeing a physician by either walking into a Project DAWN distribution site or visiting a participating pharmacy. This legislation even allows physicians to authorize an individual to dispense naloxone under protocol at any location that holds a terminal distributor license.

What this Means for Physicians and Patients

This means that your patients will have greater access to naloxone than ever before. As a physician, you can develop a protocol in your own practice to allow staff to train and dispense naloxone to at-risk individuals or refer them to a program or location that offers the service. This means that your patients will be safer and more likely to survive their overdose and receive treatment for addiction with passage of House Bill 4. To learn more, read about Project DAWN at www.metrohealth.org/projectdawn. ■

PUBLIC HEALTH ISSUES

The following is reprinted from the spring 2015 issue of the Ohio Family Physician with permission from the Ohio Academy of Family Physicians.

The location of Ohio's I-70 and I-75 corridors is ideal for human and sex trafficking. The FBI has named Toledo, OH, as the fourth worst city in the country for such trafficking. This past September, a father and son were found guilty of sex trafficking in Columbus, OH, where victims were recruited through the Internet; heroin, violence, and threats were used to force women and children into prostitution in the city's hotel rooms. An estimated 2,879 native Ohio adolescents are at risk for sex trafficking and another 1,078 have been trafficked into the sex trade over the course of a year. Approximately 18% of Ohio's victims said they became involved in the sex trade before age 18 and 10% said they became involved before age 12.

Victims are recruited because of many reasons, but two significant reasons are Ohio's proximity to Canada and the interstates running through Ohio that connect many urban communities across rural landscapes. The victims are recruited, hidden in less populated areas, and then transported across state lines. In addition, the growing immigrant population has increased the numbers of victims that are trafficked for labor.

Ohio is Addressing the Issue

Governor John Kasich made human trafficking an important issue in his initial gubernatorial campaign. He delivered on his promise by appointing the first statewide anti-trafficking coordinator, Elizabeth Ranade-Janis, and created the 2012 Ohio Human Trafficking Task Force. Two major bills have passed and have been signed into law increasing the penalties for offenders, increasing awareness for the public and first responders, as well as making more resources available for victims and survivors.

Because adolescents are the most targeted age group, the Ohio Human Trafficking Task Force, Ohio Department of Job and Family Services, and Ohio Department of Public Safety began in 2013 training medical professionals in the treatment of minors involved in sex trafficking and implementing community resources for victims. The program is expected to last through 2015 and will commit over $500,000 in the direct treatment and advocacy of juveniles involved in human trafficking through a partnership with the Ohio Network of Children's Advocacy Centers. As a result of Ohio's activities to address this issue, Polaris Project, a national organization whose mission is to fight human trafficking, ranked Ohio in the top tier of states for addressing human trafficking concerns.

What do Trafficking Victims Look Like?

Children, immigrants, adolescents, and women are most at risk, especially those who have limited economic options or live on the margins of society—those individuals that might be questioning their sexual preference, school dropouts, those who are homeless, or those that might be fleeing political conflict in their home countries. Young teens who have older boyfriends may also be victims. Perpetrators/handlers promise jobs or better life circumstances. Like victims of domestic violence, victims of sexual or labor trafficking are often isolated with restrictions on who they can see, what they can do, and where they can go. Perpetrators may exercise financial control, intimidate, and threaten physical and sexual violence. Drug and alcohol dependencies often complicate the victim's problems.

What Does a Family Physician Need to Know?

Physicians should be both alert and aware when caring for patients who may be victims. Almost one-third of sex trafficking victims have had some point of contact with a physician or other health care professional. Victims may appear confused as to where they are, unaware of local landmarks or local events, and may give vague descriptions. They may lack identification or their perpetrators/handlers have the information and may answer questions for them. Victims may also respond only after visual consultation with their handlers/perpetrators. Sex trafficking victims may also be scared of dealing with the police.

As with domestic violence victims, if you think a patient is a victim of trafficking, you do not want to begin by asking directly if the person has been beaten or held against their will. Instead, start at the edges of their experience. And, if possible, you should enlist the help of a staff member who speaks the patient's language and understands the patient's culture, keeping in mind that any questioning should be done in confidence. If using an interpreter, screen the interpreter to ensure they do not know the victim or the traffickers and do not otherwise have a conflict of interest.

Suggested Tips

- Listen and observe for clues
- Be nonjudgmental
- Interview the victim separate from the handler/perpetrator
- Assure confidentiality
- Assure that no one deserves to be hurt or afraid
- Share resources
- Minors should be reported to child protective services.

Health Care Problems Seen in Trafficking Victims

- Sexually transmitted diseases, HIV/AIDS, pelvic pain, rectal trauma, and urinary difficulties from working in the sex industry
- Pregnancy, resulting from rape or prostitution
- Infertility from chronic untreated sexually transmitted infections or botched or unsafe abortions
- Infections or mutilations caused by unsanitary and dangerous medical procedures performed by the trafficker's so-called "doctor"
- Chronic back, hearing, cardiovascular, or respiratory problems from endless days toiling in dangerous agriculture, sweatshop, or construction conditions
- Weak eyes and other eye problems from working in dimly lit sweatshops
- Malnourishment and serious dental problems—these are especially acute with child trafficking victims who often suffer from retarded growth and poorly formed or rotted teeth
- Infectious diseases like tuberculosis
- Undetected or untreated diseases, such as diabetes or cancer
- Bruises, scars, and other signs of physical abuse and torture—sex industry victims are often beaten in areas that won't damage or show their outward appearance, like their lower back
- Substance abuse problems or addictions either from being coerced into drug use by their traffickers or by turning to substance abuse to help cope with or mentally escape their desperate situations
- Psychological trauma from daily mental abuse and torture, including depression, stress-related disorders, disorientation, confusion, phobias, and panic attacks
- Feelings of helplessness, shame, humiliation, shock, denial, or disbelief
- Cultural shock from finding themselves in a strange country.

Suggested Screening Questions

- Can you leave your job or situation if you want?
- Can you come and go as you please?
- Have you been threatened if you try to leave?
- Have you been physically harmed in any way?
- What are your working or living conditions like?
- Where do you sleep and eat?
- Do you sleep in a bed, on a cot, or on the floor?

- Have you ever been deprived of food, water, sleep, or medical care?
- Do you have to ask permission to eat, sleep, or go to the bathroom?
- Are there locks on your doors and windows so you cannot get out?
- Has anyone threatened your family?
- Has your identification or documentation been taken from you?
- Is anyone forcing you to do anything that you do not want to do?

Physician & Patient Resources

Training materials for physicians and other health care professionals are available at http://www.acf.hhs.gov/programs/orr/resource/rescue-restore-campaign-tool-kits#health. Physicians can assist patients by knowing what resources are available in their area. Polaris Project has a large amount of resources including a directory of resources in every state. In Ohio, the Salvation Army runs a hotline to assist victims; the phone number is (614) 285-4357(HELP).

- State of Ohio: humantrafficking.ohio.gov/
- Ohio Sex Trafficking Hotline: (614) 285-4357, www.centralohiorescueandrestore.org/
- National Hotline: (888) 373-7888, www.traffickingresourcecenter.org/
- Polaris: www.polarisproject.org/ ■

REFERENCES

References for this article are available at www.ohioafp.org/news-publications/the-ohio-family-physician.

Christen Johnson is a second-year medical student pursuing a medical degree and master of public health from the Wright State University Boonshoft School of Medicine, Dayton, OH. Her goals include being a family physician with a special interest in adolescent medicine.

Maggie Rechel is a second-year medical student at Wright State University Boonshoft School of Medicine, Dayton, OH, and hopes to practice primary care. She has done doctoral work in sociology. Her research interest includes unintended pregnancies and mental health issues of adolescents and young adults.

Dr. Zink is the chair of the Wright State University Boonshoft School of Medicine Department of Family Medicine, Dayton, OH. She has done research in intimate partner violence and sexual assault.

Local Cuyahoga County Consortium is Working on Building Opportunities for Everyone in the County to Have a Fair Chance to be Healthy

By Nichelle Shaw, Cuyahoga County Board of Health, and Heide Aungst, Case Western Reserve University School of Medicine

There may be a day when physicians check a patient's blood pressure, heart rate, and ZIP code. In some urban areas of Cuyahoga County, residents have poorer health and live up to 20 years less than their suburban neighbors.

Cleveland is like many other under-resourced cities throughout the country where access to opportunity is divided largely by race and ethnicity. Cuyahoga County residents with the poorest health live in urban African-American and Hispanic neighborhoods, where long-standing systems and policies hinder residents from accessing healthy foods, attaining quality education, and obtaining jobs and economic stability.

Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga) is tackling these difficult issues. On June 11, HIP-Cuyahoga released the first-ever Cuyahoga County Community Health Improvement Plan (CHIP), a comprehensive report focused on ways to create equity for a healthier Cuyahoga County, especially in its urban core.

The CHIP represents years of research, community engagement, cooperative planning, and shared decision making, targeted at promoting opportunities for all to reach their fullest health potential. More than 50 partner organizations—about 100 individuals representing residents, health care systems, academia, government, and public health—worked together to create the document, and they continue to work together to make changes in the community. (A full copy of the CHIP can be downloaded at www.hipcuyahoga.org.)

HIP-Cuyahoga's Mission & Priorities

Those changes are part of advancing HIP-Cuyahoga's mission "to inspire, influence, and advance policy, environmental, and lifestyle changes that foster health and wellness for everyone who lives, works, learns, and plays in Cuyahoga County."

In addition, HIP-Cuyahoga identified four key priority areas, outlined in the CHIP, for subcommittees to work on:

- ***Eliminating structural racism.*** Structural racism is a silent opportunity killer. While many deny personal racism, structural racism thrives on old policies, such as redlining, that would not allow home loans based on neighborhood, regardless of an individual's ability to pay. This created neighborhoods where inequities flourish. To address root causes, HIP-Cuyahoga members will look within their own organizations to transform them by adopting policies, values, and practices based on inclusion and fairness. "You must change to get change, and you must think differently to do differently," says Greg Brown, HIP-Cuyahoga co-chair and structural racism subcommittee co-anchor.
- ***Linking public health and clinical care.*** Cuyahoga County consistently ranks in the top 10 nationally for excellent clinic care, but ranks toward the bottom for individual health. This is because health is more than health care. Although health systems focus on quality and access, underlying structural and policy issues shape opportunities for health. Low education, poverty, and lack of social support impacts health, and that's the focus of public health. To bridge the two areas, this subcommittee is working with both public health departments and local hospital systems and clinicians to facilitate data collection and coordinate required health assessments to better understand how to address the health challenges in the county. In addition, the subcommittee will work with other partners to pilot a program addressing asthma.
- ***Improving accessibility to Healthy Eating, Active Living (HEAL) opportunities.*** Patterns of sprawl and population shifts have left neighborhoods without access to stores that sell fresh produce, with little green space for exercise, and with safety concerns. Sometimes the environment and lack of resources means that even when residents want to make healthy choices, they can't. This subcommittee will work with residents to identify local corner stores that could sell healthy produce and food, in a sustainable way.
- ***Improving chronic disease management.*** Chronic diseases, such as diabetes, high blood pressure, and heart disease, can reduce quality of life and increase costs for those impacted. Environmental factors, such as stress, unemployment, and financial problems—along with poor lifestyle choices, like smoking or not exercising—can exacerbate these diseases, leading to poorer health and earlier death. African Americans have a higher rate of high blood pressure and poorer control of it than their white counterparts. This subcommittee will support use of the HealthSpan (formerly Kaiser) hypertension best practice model in areas of need. The model includes new protocols to ensure accurate blood pressure readings, simplified medication instructions, and cultural sensitivity training for clinicians to build trusting relationships with patients.

NOTE: A special grant from the Centers for Disease Control and Prevention (CDC) will help support both the HEAL and improving chronic disease management efforts.

How Can You Help?

With the subcommittees taking the first steps to implement initiatives addressing each priority, HIP-Cuyahoga will move forward with developing communication strategies so people throughout the county will understand our work, as well as with establishing a system to collect data necessary to measure the impact of our efforts.

In addition, HIP-Cuyahoga has put forth a call-to-action for residents, partners, and policy makers to help us create opportunities for everyone in Cuyahoga County to be healthy.

Here's how you can help:

- **Join our partnership.** No single person or organization alone can create such a large-scale and lasting change as we can together.
- **Help us tell a different story.** A story that tells about the most pressing issues impacting health in our county, not the story that relies solely on health being a product of personal responsibility.
- **Begin by understanding.** Build knowledge, both personally and professionally, on health and equity through open and honest discussions about how economic, social, and environmental factors such as racism, poverty, poor education, unsafe housing, and poor food access contribute to differences in health outcomes that have negative impacts for our entire county.
- **Work with us.** Help us to increase community engagement. Ensure that we include community members, especially those impacted by inequities, in all aspects of planning, implementation and evaluation. Gaining community input and buy-in is critical to achieving sustainable change; building trusting relationships and community ownership can lead to lasting changes.
- **Assist us with increasing understanding.** Help us to inform policy and decision makers on how historical policies and practices have shaped our current inequities. Help them to understand that this can be done through policy making, through hiring and recruitment practices, and through funding and resource allocations.

"A community is only as healthy as its unhealthiest citizens. The health of our community is best determined by the health of all of our people," says Scott Frank, MD, the health commissioner of the Shaker Heights Health Department and member of the HIP-Cuyahoga steering committee.

We *all* pay for poor health. Economically, the cost is substantial due to disability and years of productive work lost. By improving the health of those with the greatest need, we generate better health for everyone. ■

To learn more or to get involved in HIP-Cuyahoga, go to www.hipcuyhaoga.org.

The Health Improvement Partnership-Cuyahoga is currently funded by the Centers for Disease Control and Prevention and the Saint Luke's Foundation of Cleveland.

Editor's note: *The AMCNO is pleased to be a partner in HIP-Cuyahoga.*

Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga) is building opportunities for everyone in Cuyahoga County to have a fair chance to be healthy.

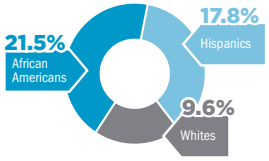
HIP CUYAHOGA Health Improvement Partnership

UNEQUAL OPPORTUNITIES + POOR HEALTH = SHORTER LIVES

African Americans and Hispanics are three times as likely to live in poverty than whites.

African Americans are more than twice as likely to be unemployed than whites.

UNEMPLOYMENT RATE IN CUYAHOGA COUNTY



African Americans and Hispanics are less likely to graduate High School than whites.

69.6% Hispanics | 81.8% African Americans | 90.2% Whites

Half of the people in Cleveland live farther than a half mile from a grocery store. More than 60% of them are people of color.

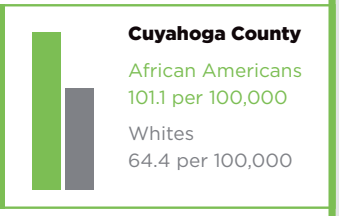
Students of color are more than twice as likely to be obese than white students.

Nationally, African Americans have a higher prevalence of high blood pressure. African Americans are also up to four times more likely to suffer increased risk of complications from high blood pressure than whites.

41% African Americans | 27% Whites

African Americans are more likely to die from a stroke than whites.

STROKE MORTALITY RATES



*2008-2010 Ohio Stroke Mortality Rates

In Cuyahoga County, three times as many African-American babies die than white babies.

Depending on where people live, there is up to a 20-year difference in Life Expectancy in Cuyahoga County. City of Cleveland and inner-ring suburbs have the lowest life expectancies.

WHY DOES IT MATTER?

In Cuyahoga County, people of color are needlessly suffering and dying before their time.

We all pay for poor health.

>$1 Trillion—the combined cost of health inequities in the U.S.

WHAT ARE WE DOING ABOUT IT?

Public health and health care systems must work together to improve the health of communities.

HIP-Cuyahoga is:

- ✔ Encouraging both systems to work together on shared goals
- ✔ Building public health and health equity training into the curriculum of health profession students
- ✔ Identifying opportunities for combined data collection to better represent community health needs

An increasing number of people of color are at risk of chronic disease and do not get the care they deserve and need.

HIP-Cuyahoga is:

- ✔ Recruiting residents to become trainers or participants in chronic disease self-management programs
- ✔ Training doctors to care for all patients with chronic disease in ways that are proven to work
- ✔ Training doctors to be culturally sensitive and speak in plain language

Structural racism limits opportunities for some but contributes to poor health for all.

HIP-Cuyahoga is:

- ✔ Teaching organizations how to recognize and address structural racism
- ✔ Encouraging organizations to work closely with community members
- ✔ Developing policies to create social and economic opportunities for all people in Cuyahoga County

Everyone should be able to eat healthy and be active if they choose to.

HIP-Cuyahoga is:

- ✔ Making healthy food available in neighborhood stores
- ✔ Making sure that new streets are built to encourage walking and biking
- ✔ Encouraging schools and churches to open their doors for people to be active after hours

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)
is Pleased to Present its Annual Seminar...

Solving the Third-Party Payer Puzzle

Join us! Representatives from private payers, Medicare and Medicaid discuss the latest changes that will impact your practice.

November 4, 2015

AMCNO Executive Offices
Park Center Plaza I
6100 Oak Tree Blvd.
Independence, OH 44131

Registration: 7:30 a.m. - 8:00 a.m.
Seminar: 8:00 a.m. - 2:00 p.m.

LUNCH WILL BE PROVIDED

AGENDA

7:30 - 8 a.m. ***Registration and breakfast***

8 – 8:45 a.m. ***Medical Mutual Of Ohio***
2015 Updates

8:45 – 9:30 a.m. ***Anthem Blue Cross Blue Shield***
2015 updates, including but not limited to:
- New Medicare Advantage precert tool
- Interactive Care Review tool (ICR)
- OrthoNet, AIM and ICD-10
- Availity

9:30 a.m. – 10 a.m. ***Break***

10 a.m. – Noon ***Ohio Medicare/CGS***
Information regarding medical record review contractors
- Comprehensive Error Rate Contractor (CERT)
- Recovery Auditor (RA)
- CGS Medical Review (MR)

Discuss new and ongoing Medicare initiatives

Noon – 12:30 p.m. ***Lunch***

12:30 p.m. – 2 p.m. ***Ohio Medicaid***
- MyCare Ohio
- Eligibility
- ICD-10
- Policy updates
- Physician credentialing tips and timelines
- Budget initiatives

For more information, contact the AMCNO offices at **(216) 520-1000** or visit **www.amcno.org.**
The event is co-sponsored by the Academy of Medicine Education Foundation.

Registration

PRE-REGISTRATION IS REQUIRED.

SEATING IS LIMITED; Please limit 2 people per office.
CUTOFF: 75 People

Register online at ***www.amcno.org/index.php?id=550***

AMCNO Member: $50
AMCNO Member Staff Person: $50
Non-member: $100

NOTE: If you register as a Member and your physician is **not** an active AMCNO Member, you will not be registered until the additional payment is received.

Payment is also accepted the day of the seminar at registration. Checks made payable to AMCNO.

Better Health Partnership Grows; Takes New Name

By Diane Solov, Better Health Partnership

Since its start in 2007, Better Health Partnership and its clinical members have focused on improving the quality of care and outcomes for primary care patients with common and costly chronic conditions, improving health across the community and supporting value-based payment models to accelerate better health at lower costs.

Recently known as Better Health Greater Cleveland, Better Health is a collaborative of health care providers, payers, purchasers and community organizations committed to the Triple Aim of better care, better health and lower costs.

Our vision is to help make Northeast Ohio a healthier place to live and better place to do business. Our mission to provide a safe place for health care competitors to collaborate is a cornerstone of our successes. In June, we changed our name to reflect our growing membership beyond Cuyahoga County to eight other counties.

Better Health's most recent report—our 15th—includes clinical quality data on care and outcomes in 2014 of 169,745 adult patients with diabetes, high blood pressure and/or heart failure cared for by over 700 primary care providers in 86 practices. Our reach has expanded significantly since our first report in 2008 that covered care for 26,075 patients of 42 practices.

More growth is anticipated. In July, Better Health's Clinical Advisory Committee and Leadership Team voted unanimously to add new measures related to children's health and health care.

Pediatricians from partner organizations have joined Medicine-Pediatric specialists and Family Physicians in a Children's Health Subcommittee that was established to recommend an initial set of conditions, risk factors, measures and standards for endorsement.

Improving Together, Sharing Best Practices

Better Health's synchronous programs and activities are designed to drive innovation, high-performing primary care and adoption of new payment systems that support quality care. Transparency is a strategic pillar. Foundational to our activities are twice yearly public reports of primary care practices' achievement and improvement on nationally endorsed and locally vetted standards of quality care for important chronic diseases. Other core programs include twice yearly Community Health Checkup events to report our progress and twice yearly Learning Collaborative Summits, where providers and other stakeholders learn with and from each other. The Summits play an important role in disseminating best practices that Better Health has identified as "bright spots" in its clinical quality data that are linked to successful practices that others can replicate.

The Partnership's growing impact has been well documented. Among the achievements we documented in the last two years include:

- 2,200 preventable hospitalizations for ambulatory care-sensitive conditions averted between 2009 and 2011 in Cuyahoga County, saving an estimated $15.4 million.
- More than 50,000 additional patients in 2014 have their blood pressure in good control than in 2009.
- Gaps in care for diabetes were eliminated among racial and income groups.
- Better Health's results beat or meet the national average in HEDIS across all types of insurance on nearly all measures. See http://www.betterhealthpartnership.org/hedis_2014.asp.

Coordinated, Patient-Centered Care

As a champion for primary care, Better Health has been a longstanding proponent for adoption and optimization of the Patient-Centered Medical Home model. Early on, we built internal expertise in the model, its components and the recognition program offered by the National Committee for Quality Assurance (NCQA), and later, the Joint Commission. Better Health has played a role in helping 68-plus practices prepare successful applications and to meet increasingly demanding standards.

Through its Learning Collaborative Summits and on-site consulting, Better Health focuses on key components of coordinated, patient-centered care and new value-based payment models. Population health management, electronic health records optimization, quality improvement, workflow redesign and building effective teams are among our core competencies. Helping providers improve their performance and readiness to successfully participate in new payment models are building blocks for transformation.

Identifying and Addressing Disparities

Better Health is committed to improving care and outcomes for all populations. Our use of clinical data extracted from electronic health records enables us to measure, report and improve care and outcomes for uninsured patients, as well as those with Medicaid, Medicare or commercial insurance.

Our diverse population of provider organizations includes all of the region's safety-net organizations, and we have been at the forefront of identifying disparities across patient groups. Every six months, disparities-relevant data are reported alongside clinical quality measures, including insurance type (Medicare, Commercial, Medicaid and Uninsured), gender, income, education, race, ethnicity and preferred language, highlighting the relationship between socioeconomic attributes and clinical outcomes.

Better Health increasingly is taking steps to help our partners and the community eliminate disparities. In 2013, we launched an initiative to close the persistent gap between good control of high blood pressure between White and African-American patients.

The high blood pressure program was a best practice identified in our routine data analyses. In our 2012 report, we noted a dramatic rise in rates of good blood pressure control among HealthSpan practices (formerly Kaiser Permanente), with up to 90% of patients in good control, including African Americans. HealthSpan had adopted new protocols to ensure accurate blood pressure readings, simplified medication regimens, stepped-up blood pressure monitoring and communications training for physicians and staff to help build trusting relationships with patients. Better Health physician leaders then developed a curriculum that physician-led practice consultants are using to help practices adopt or adapt.

At the Nexus of Clinical Care and Community Health

Better Health is actively involved in HIP-Cuyahoga (HIP-C), a consortium of more than 100 community partners created by the Cuyahoga County Board of Health (CCBH). HIP-C focuses on four key priorities in Cuyahoga County's first Community Health Improvement Plan—released in June—including one targeting chronic disease management.

Better Health plays a leadership role in HIP-C. We sit on HIP-C's Steering Committee and serve as the "anchor" organization for the Chronic Disease Management priority, with

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Better Health Partnership Grows; Takes New Name

(Continued from page 13)

which our work is well aligned. HIP-C has enabled us to expand the hypertension intervention, the result of a $3 million award to CCBH from the Centers for Disease Control and Prevention for a "REACH" grant (for Racial and Ethnic Approaches to Community Health). With REACH, Better Health practice sites in targeted neighborhoods where health disparities are high also are linking patients with community resources for healthy food, exercise and self-management.

High-Value Health Care Delivery and Payment Systems

Policy changes at the federal and state levels promise to reshape healthcare delivery and payment. Better Health is playing advisory roles in programs being developed by Ohio Gov. John Kasich's Office of Health Transformation, which plans to blanket the state with patient-centered primary care and value-based purchasing.

The state is focusing on expanding adoption of the Patient-Centered Medical Home model and introducing payment models that reward better care, better health, and lower costs of care. The goals are that at least 80% of Ohioans will have access to patient-centered primary care and 80-90% of Ohio's population will receive health care that is paid for based on its value—that is, accountable for both quality and cost.

In December 2014, Ohio was awarded a four-year, $75 million federal grant (Ohio's "State Innovation Model" or SIM) that it will use to launch payment reforms. An important first step was the state's pledge to wield its power as Ohio's largest purchaser of healthcare services; between state employees, their dependents and Ohioans with Medicaid insurance, state taxpayer dollars pay for the health care benefits of 2.8 million Ohioans.

Ohio leveraged this buying power to secure commitments from large health insurance companies to implement payment and delivery system changes for their enrollees. In addition to contracted Medicaid managed care plans, Ohio's multi-payer coalition includes Aetna, Anthem Blue Cross Blue Shield, Medical Mutual of Ohio and UnitedHealthcare, which together account for the payments of four or every five Ohioans with commercial insurance.

Private employers in Northeast Ohio also are venturing into value-based purchasing arrangements. In October 2014, Lubrizol Corp., Lake County Schools Council and Progressive Group of Insurance Companies launched a pilot program with Lake Health System to provide coordinated, patient-centered care for their employees and dependents who receive care from primary care and specialty physicians in its group. Improving workforce health and decreasing healthcare costs are the goals of the pilot.

The project was facilitated by Health Action Council, a nonprofit organization of large, self-insured employers that provides healthcare coverage for nearly 2 million people. Better Health provides its expertise and analyses on quality and outcomes data to monitor effectiveness.

Other value-based payment reform initiatives led, designed, supported and evaluated by *Better Health* include Red Carpet Care, which targeted "high-utilizer" patients, and CarePlus, a Medicaid-like insurance program led by MetroHealth that was extended to previously uninsured patients prior to Medicaid expansion in Ohio. These novel programs delivered better health outcomes at lower costs for high-cost patients.

At Better Health, we believe innovation, transparency and collaboration are vital tools for navigating the changes underway in the healthcare system. Join us, as we transform health care, together. Visit www.betterhealthpartnership.org. ■

Editor's Note: *The AMCNO has been an active participant in BHP since its inception in 2007.*

Community Works Together to Raise Immunization Awareness

August was National Immunization Awareness Month. Although immunizations have significantly reduced the incidence of many serious infectious diseases, vaccination rates for some diseases are not meeting national public health goals, according to the National Public Health Information Coalition (NPHIC). People need to be reminded that immunizations aren't just for babies and young children—they're also necessary for adolescents and adults, spanning a lifetime.

The AMCNO received communications from the American Academy of Pediatrics Ohio Chapter and the Ohio Department of Health, who led the effort to increase awareness during August. Among the items was a toolkit created by the NPHIC and the Centers for Disease Control & Prevention's (CDC) National Center for Immunizations and Respiratory Diseases, which could be used to assist physicians, community leaders and local organizations in communicating the importance of immunizations to the public.

Each week, themes focused on a specific group of the population—newborns to age 6, school-aged kids (preschool to college), preteens to teens, pregnant women and adults.

Just in time for the start of the school year, the School-Aged Kids kit relayed the important measures parents should take before their children join their classmates. Parents were encouraged to talk with their physician, specific school or health department about what vaccinations their children may need—whether they were just starting kindergarten or attending college.

The Birth to Age 6 kit discussed how parents can provide the best protection by following the recommended immunization schedule. It was found that 88.9% of parents reported that they are vaccinating according to schedule or are intending to do so. The CDC, the American Academy of Family Physicians and the American Academy of Pediatrics offer "Provider Resources for Vaccine Conversations with Parents." These materials are free and available at http://www.cdc.gov/vaccines/hcp/patient-ed/conversations/index.html.

The other kits conveyed the same strong message that immunizations help protect people throughout various stages in their lives—from serious but treatable diseases—and future generations as well.

You can check out the AMCNO Twitter feed and Facebook page to see how we communicated this valuable information. ■

The Affordable Care Act: Exchanges & Tax Credits In The Supreme Court's *King V. Burwell* Decision

By Brian T. Gannon, Esq. and Catherine Sturik, Esq.

Though five years have passed since the Affordable Care Act ("ACA") went into effect, the ACA continues to be challenged, interpreted, and clarified through every level of the judiciary. On June 25, 2015, the Supreme Court issued its most recent opinion in another noteworthy ACA case, *King v. Burwell*, which examined the applicability of the ACA's tax credit incentive to health insurance exchanges established by the federal government.

Despite concerns of increased premiums, a rise in the number of uninsured health care patients, and a substantial drop in the number of individuals mandated to purchase health insurance, the Court found the tax credit incentive applies equally to federal and state exchanges—closing a potential "loophole" to the ACA's insurance mandate.

The ACA: Mandatory Health Insurance, Exchanges, and Tax Credits

One of the most well-known and controversial elements of the ACA is its requirement that all individuals maintain health insurance. Failure to comply with this insurance mandate subjects an individual to a penalty payment to the Internal Revenue Service ("IRS"). Notably, however, there is one specific exemption to the coverage requirement: if the cost of buying health insurance exceeds eight percent (8%) of an individual's income, that individual is not required to purchase health insurance.

In addition to the insurance mandate, the ACA also requires the creation of an "exchange" in each state. An exchange is intended to function as a marketplace where individuals can compare and purchase health insurance plans. Each state is given the opportunity to establish its own exchange; however, it is not mandatory. Should the state elect not to establish its own exchange, the federal government will establish and facilitate an exchange for the state, through its website *healthcare.gov*. To date, more than thirty states, including Ohio, have opted for a federal exchange.

To incentivize individuals to purchase insurance plans through their state's exchange, the ACA provides a tax credit for any applicable taxpayer who enrolls in an insurance plan through "an exchange established by the State." These tax credits are given to individuals whose household incomes are between 100 percent and 400 percent of the federal poverty line.

Significantly, the ACA does not explicitly distinguish whether the clause "established by the State" also includes exchanges created and maintained by the federal government. With that, the IRS broadly interpreted the clause to apply the tax credit to all exchanges, regardless of whether the state or federal government created the exchange.

Tax Credits for Federal Exchanges, too?

In *King v. Burwell,* Virginia residents challenged the IRS's application of the tax credit to federally-established exchanges. The residents argued that the words "established by the State," as specifically provided in the ACA, preclude the tax credit for individuals who enroll with any federal exchange.

Thus, according to the Virginia residents and petitioners in the *King v. Burwell* case, without the tax credit incentive, purchasing health insurance would exceed eight percent (8%) of their income—meaning they were wholly exempt from the mandate and thereby not required to purchase health insurance.

Accordingly, the issue before the Supreme Court was the following: did the ACA's tax credit, applicable to taxpayers who enroll in an insurance program through "an exchange *established by the State,*" apply to exchanges established by the federal government?

The Risks: Rise in Uninsured and Threat to Hospital Industry

At the time of the *King* decision, more than half of the states' exchanges, including that of Ohio, were established and administered through the federal government. There was a significant concern that should the Court decide that the tax credit did not apply to the federal exchanges, it would exempt a substantial number of individuals from receiving tax credits, thus placing a larger group of individuals below the eight-percent (8%) of income cut-off for mandatory health insurance.

Several hospital organizations, including the Federation of American Hospitals and the American Hospital Association, filed friend-of-the-court briefs in support of retaining the tax credit incentive for federally-established exchanges. In its brief, the American Hospital Association noted that an estimated five million Americans will rely on tax subsidies to obtain health insurance coverage in 2015 alone. In fact, by the year 2022, 19 million Americans will need subsidies to purchase health insurance, 72% of whom reside in states with federally-facilitated exchanges. Eliminating the tax subsidy for federal exchanges would result in a substantial decrease in individuals who would be required to maintain health insurance.

Financial and economic harm to hospitals and medical providers was also an overwhelming concern. The Federation of American Hospitals highlighted the substantial funding cuts for hospitals by the ACA and potential financial peril in the event the Court eliminated tax credits for federal exchanges:

> *Hospitals will incur significant financial harm if subsidies suddenly disappear across most of the country. In the ACA, Congress imposed deep cuts to federal funding for hospitals. But it expected that the subsidies it included in the statute would bring newly insured patients to hospitals, helping them offset the loss. An ACA without subsidies would leave hospitals unable to make up the loss in their funding. That could imperil some hospitals, and will make it more difficult for others to carry out their missions, including effectively serving their communities.*

The American Hospital Association also recognized the substantial burden that uninsured patients pose to hospitals. In 2011, the value of uncompensated care to patients, for which hospitals were never reimbursed, added up to $41.1 billion dollars. Denying subsidies to states with federal exchanges would lead to "more uninsured patients than anyone anticipated," who would be forced to

(Continued on page 16)

The Affordable Care Act: Exchanges & Tax Credits In The Supreme Court's *King V. Burwell* Decision *(Continued from page 15)*

rely on hospitals to provide unreimbursed care. The Urban Institute estimated that the hospital industry would lose $6.3 billion in revenue if the Court eliminated the tax credit for federal exchanges.

The *King v. Burwell* Decision

The Supreme Court ultimately found the tax credit does apply to both federal and state exchanges. In a 6-3 opinion written by Chief Justice John Roberts, the Court looked to the "statute as a whole" to conclude tax credits are available for insurance purchases on any exchange created under the ACA. According to the Court's majority opinion, because eliminating tax subsidies in federal exchanges would frustrate the ACA's major reforms, it is "implausible" that Congress meant the ACA to operate in state exchanges differently than in federal exchanges.

Notably, while the Court ultimately agreed with the IRS's interpretation of the ACA, the Court concluded it is the judiciary's role, not the role of an administrative agency, to interpret the statute.

Several friend-of-the-court briefs were also cited in the Court's opinion, recognizing the potential chilling effect on the insurance market if the Court found that the tax credit applied only to state exchanges. The Court noted the anticipated rise in insurance premiums and the significant decline in the number of individuals subject to the insurance mandate. The Court specifically acknowledged that in 2014 "approximately 87 percent of people who bought insurance on a federal exchange did so with tax credits, and virtually all of those people would become exempt."

Three Supreme Court Justices dissented in a critical, colorful opinion written by Justice Antonin Scalia. The dissenters criticized the Court's interpretation that exchanges "established by the State" included exchanges not established by the states. Justice Scalia even remarked that "normal rules of interpretation seem always to yield to the overriding principle of the present Court: The Affordable Care Act must be saved."

Despite Justice Scalia's sharp dissent, the Court's opinion remains: tax credits apply to all exchanges, regardless of whether the exchange is state or federally-created.

Now What?

Because the Court's decision affirmed the applicability of tax credits to enrollees in state and federal exchanges, it is anticipated the states that currently maintain their own exchanges will opt for a federally facilitated exchange, rather than incurring the cost and expense of maintaining their own.

Administrative agencies are also bound by the Court's interpretation and cannot reinterpret the ACA to outlaw tax subsidies. Due to the Court's finding that interpreting the ACA was its role, and not the role of the IRS or any other administrative agency, tax subsidies for both federal and state exchanges cannot be challenged in another administrative forum.

To some extent, the Court's decision has allayed the concerns of increased premiums, of an increased number of people exempt from the insurance mandate, and of the increased costs of care. Applying the tax credits to each exchange in every state reinforces the insurance requirement. So long as the cost of health insurance does not exceed eight percent (8%) of an individual's income, which includes the tax credit, health insurance remains mandatory.

For Ohio, the Court's decision affirmed that the tax credit incentive applies to Ohio's federally-facilitated exchange.

All in all, *King v. Burwell* was a significant decision for individuals, families, health care organizations, and the insurance market. It is certainly not the end of the road for the debate over the ACA, although most agree it is here to stay in some form or fashion. Given the controversial and heavily politicized nature of the ACA, coupled with the statute's ambiguous and "inartful drafting," further challenges to the ACA are to be expected. But for now, the tax credit incentive applies to all exchanges, regardless of whether they are state or federally-created. ■

Community Leaders will Gain Insight into a Physician's "Typical" Day

It's time once again for the AMCNO Annual Mini-Internship program, a unique 2-day experience that allows community leaders to shadow physicians during their daily routines. This year's event will take place October 26-28.

Physicians will be introduced to their assigned "interns" during the Orientation Dinner on the 26th, and the pairs will attend their scheduled assignments on the 27th and 28th. The program will conclude on the 28th with a Debrief Dinner, where all participants will have the opportunity to share their personal experiences.

The program is designed to improve understanding and communication between the medical profession and those in the community who influence, establish and report on healthcare policy in Northeast Ohio. It is a two-way information exchange that is intended to broaden the perspectives of all participants.

The AMCNO is still looking for physicians willing to volunteer for this important program. AMCNO members interested in participating in the mini-internship program may contact Ms. Abby Bell at the AMCNO offices at 216-520-1000, ext. 101 or email her at abell@amcno.org.

Medicare and Medicaid Celebrate 50 Years

On July 30, 1965, President Lyndon B. Johnson signed legislation to establish the Medicare and Medicaid programs. This year marked the 50th anniversary of that important act.

In the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) archives, from the 1965 Board of Directors meeting notes, the Board had approved "a resolution regarding the new Medicare program, noting that physicians should become informed about the terms of the new law, and further noting that no physician is compelled to provide services under the provisions of the bill. Each member physician must decide what course of action to take in respect to the bill, being mindful of providing the best medical care to the patient." And, the Board also approved "sending a news release to the public advising all persons over 65 to sign up for Part B of the Medicare bill, which covers medical-surgical services."

When the Medicare and Medicaid programs were first established, they provided basic health coverage for Americans. These programs have evolved throughout the years, however, to provide more Americans with improved access to quality and affordable healthcare coverage, which has, in turn, transformed the delivery of health care in the United States. Today, 111 million people are enrolled in Medicare and Medicaid, and these programs account for $1 trillion in federal spending.

In the 50 days leading up to the anniversary date, the Centers for Medicare & Medicaid Services (CMS) shared daily facts and posts on its Twitter feed and website to highlight the people, places and progress that helped shape the programs into what they are today.

"The 50th anniversary of Medicare and Medicaid provides an important opportunity for us to reflect on the critical role these programs have played in protecting the health and well-being of millions of families," said Andy Slavitt, acting administrator of the CMS. "Today, Medicare and Medicaid are creating a health care system that is better, smarter, and healthier—setting standards for how care is delivered. As we take a moment to reflect on the past five decades, we must also look to the future and explore ways to strengthen and improve health care for future generations."

Local groups and advocates also commemorated the anniversary.

"For the last 50 years, Medicaid has made health coverage a reality for millions of Ohioans," said Trey Daly, Ohio State Director for Get Covered America. "As we continue our work with our partners to make sure that Ohioans enroll in and retain health coverage, we're thankful that Medicaid has and will continue to provide thousands of working families in Ohio with quality, affordable health care."

Daly summarized Medicaid's impact in Ohio and throughout the country with the following numbers:

- **71.1 million.** The total number of Americans enrolled in Medicaid or the Children's Health Insurance Program (CHIP).
- **12.3 million.** The number of Americans who have enrolled in Medicaid or CHIP coverage since the Health Insurance Marketplace opened in October 2013.
- **2.9 million.** The total number of Medicaid enrollees in Ohio.
- **596,000.** The increase in the number of Medicaid enrollees through Ohio's expanded Medicaid program, which began in January 2014.
- **0.** The number of dollars a Medicaid enrollee will spend on preventive care.

U.S. Sen. Sherrod Brown (D-OH) addressed the programs' anniversary during a call-in with media, applauding what the programs have done for Americans, but adding that more work needs to be done.

"Looking ahead, we must look for ways to improve these programs and to eliminate disparities and barriers to care that persist," he said. "By strengthening these programs, we can ensure that more Americans can benefit from their life-changing services."

Howard Bedlin, Vice President for Public Policy and Advocacy for the National Council on Aging, also commented on the programs' future.

"Medicare and Medicaid are woven into the very fabric of American life and provide lifelines to seniors and individuals with disabilities in need—yet they are under constant threat from policymakers," he said. "We need to move beyond the rhetoric and focus on the facts, so we can make informed, rational decisions about how to protect and strengthen these critical health programs for the future."

Bedlin added, "Medicare covers 55 million Americans, about 17% of the U.S. population. With emerging new payment and delivery models, it continues to shape innovations throughout America's health care system…But as the demographics of America change, so too must Medicare and Medicaid to keep up."

The AMCNO acknowledges this special milestone in American history, and we will continue to provide members with the latest Medicare and Medicaid information through our website www.amcno.org and other communications. ■

2015 AMCNO Lawyer Referral Brochure Now Available to AMCNO Members and Staff

If you are in need of legal counsel in a specific area of expertise, the AMCNO Lawyer Referral Brochure could be of assistance to you. When legal questions or issues arise, the AMCNO believes it is important for its members to obtain sound advice from legal counsel who are knowledgeable in relevant areas of the law and who have a commitment to the effective representation of physicians and their practice groups. This brochure is the product of our effort to identify such attorneys. We encourage our members to make use of these lawyers (or other practitioners similarly qualified) whenever they encounter significant legal issues. The AMCNO does not endorse any one law firm over another – this information is provided to our members as a service only. Members are free to choose an attorney from this brochure or from other sources.

Visit our website www.amcno.org for the updated brochure. Click on the Practice Resources tab, then AMCNO Lawyer Referral Brochure.

2015 AMEF GOLF OUTING

A Big Round of Applause to the 2015 Golf Outing Participants and Sponsors!

On August 3, golfers once again teed off for the Academy of Medicine Education Foundation's (AMEF) 12th Annual *Marissa Rose Biddlestone Memorial Golf Outing*.

This year, at the Barrington Golf Club (a Jack Nicklaus Signature Course), foursomes tested their expertise in a tournament to raise money for AMEF, which was established for charitable, education and scientific purposes. These monies will be utilized for medical student scholarships, annual CME seminars and grants for health-related programs.

The day went smoothly as golfers dropped off their bags, registered, practiced their shots and enjoyed a leisurely lunch in the warm summer air. The shotgun start was at precisely 1 p.m., and the game was on! Here are the results:

1st Place Team: Brian Gannon, Brook Hamilton, Joe Palcko, Steve Walters

2nd Place Team: Jacob Ehlers, Lindsey Ehlers, Al Santilli, William Seitz, Jr., MD

3rd Place Team: Kevin Ellison, Jordan Liff, Scott Liff, Bill Zollinger

Skill prizes were also awarded:

Closest to the pin: Davis Young, David Bastulli, Don Kelly, and James Coviello, MD

Longest drive: Scott Liff #9, Don Kelly #14

Longest putt holed: Al Page

Cocktails were enjoyed as everyone relaxed after some challenging holes, then came a delicious dinner, awards, a great speech by Dr. John Bastulli and a fun prize raffle.

A special **thank you** goes to Classic Auto Group — Jim Brown and Dr. Victor Bello for sponsoring the hole-in-one contests. And thank you to all the event, hole and hole-in-one sponsors who helped make the day such a huge success.

Thank you to 2015 Event Sponsors:
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Thank you to 2015 Hole-In-One Sponsors:
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Sisters of Charity Health System
George V. Topalsky, MD

Prepare now and SAVE THE DATE for next year's AMEF Golf Outing!
August 8, 2016, at Sand Ridge Golf Club. See you there!

AMCNO MEMBER RECRUITMENT ACTIVITIES

Recruitment Efforts Bring Residents into the AMCNO Fold

A resident at MetroHealth Medical Center signs up for AMCNO membership.

AMCNO Past President Dr. James Coviello provides remarks during the University Hospitals resident orientation.

AMCNO Past President Dr. George Topalsky helps distribute AMCNO membership forms to UH residents.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) welcomed more than 400 new resident members into the organization during recent orientation events held around the region. The new members are from the following institutions: The Cleveland Clinic, MetroHealth Medical Center and University Hospitals.

Congratulations to these new members!

If you know of a resident who would be interested in free AMCNO membership, direct him/her to apply online at www.amcno.org. The application can be found under the Membership tab.

The AMCNO and AMEF Meet and Greet First-Year Medical Students

The AMCNO and Academy of Medicine Education Foundation (AMEF) were pleased to co-host the Case Western Reserve University Society Dean Mixer for first-year medical students. The event was once again held at the Cleveland Botanical Gardens. Dr. Matthew Levy, AMCNO president, attended this year's event along with AMCNO staff. Staff and Dr. Levy mingled with the students and society deans, providing information and answering questions about the organizations' activities. Dr. Levy then provided brief comments to the group and encouraged the first-year medical students to become involved in the organization. He explained that the AMCNO is a group of dedicated physicians who are working to improve quality of care, while providing education and community outreach in our community.

During the event, the students asked about the activities of the organization and the foundation; many were not aware that such organizations existed and were pleased to learn that they could participate as medical students. Many expressed interest in the work of the AMCNO and several had questions about their career and specialty choices, while others expressed an interest in volunteering and outreach activities. AMCNO staff was on-hand to provide membership information, and we are pleased to welcome more than 120 new medical student members.

Medical students line up at the Cleveland Botanical Gardens to become AMCNO members.

The students gather to hear their deans and AMCNO President Dr. Matthew Levy (pictured) speak.

Most people think you call hospice when you're all out of options. That's not true if you call Hospice of the Western Reserve. As Northern Ohio's most experienced and most referred hospice provider, we offer more options to personalize care. Our patients and their families live their lives where they choose–at our unique facilities, at home, at a hospital, at a nursing home or at an assisted living residence. See why more families choose the hospice of choice at **hospicewr.org**.

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