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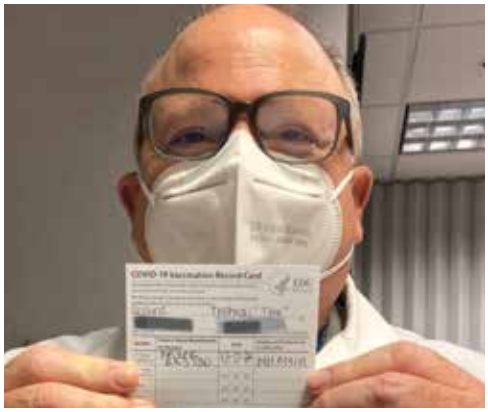
A Message from the Executive Director

As we enter March and mark a year of the COVID-19 pandemic in the United States, I want to take this opportunity to thank each and every one of you for your work during these trying times. We have seen physicians across our region stand up and serve their patients and our community despite insurmountable odds not seen in our lifetimes.

With the levels of vaccinations rising daily, we now know there is an end in sight. We at AMCNO remain dedicated to you, and to the goal of vaccinating our communities in the coming months. The voice of our physician community must and will be heard as we work to get out of this pandemic.

For those of you needing resources for yourselves and your patients, please reach out to us directly, or see some of the helpful content in this edition of the *Northern Ohio Physician.* For those who would like to volunteer at vaccination events, please visit www.ohioresponds.odh.ohio.gov and select the "Register Now" button on the homepage to begin the registration process.



Dr. Thomas Collins, President of AMCNO, receives his first dose of the COVID-19 vaccine.

Thanks to the physicians of the Academy of Medicine of Cleveland in 1962, Cuyahoga County had the best record in the United States when it came to vaccinating residents with the Sabin vaccine for polio. That legacy is something to be proud of, and for us to use as inspiration as we imagine our organization's future.

I hope that you will join us in the coming months as we re-brand and re-imagine the AMCNO, to ensure as we approach our 200th birthday in 2024 that we are meeting the needs of the physicians of today and tomorrow. You can start in a small way today by helping us choose our new logo (see page 7).

Thank you for the opportunity to serve you.
Jen Johns, MPH
Executive Director, Academy of Medicine of Cleveland & Northern Ohio

AMCNO President Dr. Thomas Collins Testifies on Interstate Licensure Compact

AMCNO President Thomas E. Collins, MD, FACEP, FAEMS, recently provided testimony to the Ohio Senate Health, Human Services and Medicaid Committee in support of Senate Bill 6. SB 6 would enter Ohio into the Interstate Medical Licensure Compact, an agreement among participating U.S. states to work together to significantly streamline the licensing process for physicians who want to practice in multiple states. Because of the ongoing COVID-19 pandemic, the testimony was written-only.

The AMCNO strongly supports this legislation because it offers a voluntary, expedited pathway to licensure for physicians who qualify. State medical boards, recognizing that physicians would increasingly practice in multiple states because of telemedicine, began actively discussing the idea of creating an interstate medical compact in 2013, with the goal of trying to help streamline traditional medical-license application processes. Since then, 29 states, the District of Columbia, and Guam have joined the compact.

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National Opioid Leadership Summit Highlights Challenges of an Epidemic Within a Pandemic

By Tara Camera, Editor in Chief

The Academy of Medicine Education Foundation (AMEF) was pleased to sponsor the 2020 National Opioid Leadership Summit, hosted virtually by the Public Health Institute (PHI) and University Hospitals (UH).

The two-day event brought together leaders from across the country to share information, experiences and solutions to the opioid crisis. Through TED-style talks, keynote presentations, and interactive breakout sessions, attendees had the opportunity to hear from those in the criminal justice, health care and public health sectors discuss what's going on at the local level and successful models and policies that could be tailored to fit each community's needs.

PHI CEO and President Mary A. Pittman and UH CEO Dr. Thomas F. Zenty III provided opening remarks, addressing the rise in addiction rates and overdose deaths related to the COVID-19 pandemic, and emphasizing the need for meaningful solutions. Dr. Zenty stressed the importance of having a plan that involves these four sectors to create change: law, education, treatment, and health care policy.

The Northeast Ohio Hospital Opioid Consortium (NEOHOC), of which the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is a member, was featured as a plenary session on the first day of the event. Dr. Randy Jernejcic, vice president of ambulatory quality and clinical transformation at UH, served as moderator. Panelists from each member organization provided an update on what is being done to address both public health crises, what has been working so far, and what they're working on for the future.

Dr. Jernejcic noted that although the hospitals are competitors, the work they have been able to accomplish together has been remarkable and the impact has been immeasurable.

Dr. Joan Papp, an AMCNO member from MetroHealth Medical Center, reported on her successes with Project DAWN (Deaths Avoided with Naloxone) and electronic health record initiatives. Dr. David Streem, with Lutheran Hospital, discussed the work he's doing to study the link between endocarditis and substance use disorder (SUD), as well as how Lutheran is working with medical students and residents to provide SUD treatment training.

Dr. Jeanne Lackamp, from the UH Pain Management Institute, provided information on the institute itself and alternative and complementary treatments. Dr. Kevin Smith, from the VA, said through an expansion project, they've been able to increase access for veterans, and provide MAT treatment as needed. AMCNO member Dr. Ted Parran, from St. Vincent Charity Medical Center, discussed Rosary Hall, a detox center that has expanded from 12 beds to 27. Their MAT-specific program is the first of its kind in Ohio.

AMCNO President Dr. Thomas E. Collins, from MetroHealth, shared the Academy's background and how pleased he is to see that the epidemic and pandemic have brought these leaders to the table to discuss progress and solutions. He also reported on the AMCNO's advocacy work on the epidemic, specifically related to alternative treatment, mental health confidentiality, and pain management.

Several sessions followed, including one focused on Huntington, West Virginia, which is one of the hardest-hit communities in the country, and how its public health providers organized to find solutions to fight addiction.

On the second day of the event, opening remarks were provided by Dr. Carmen Nevarez, senior vice president, Public Health Institute, and Dr. Daniel Simon, chief clinical & scientific officer, UH, and president of UH Cleveland Medical Center. Dr. Simon touched on the work of NEOHOC and shared lessons learned from the pandemic, including the need to be resilient, agile, and resourceful. He then introduced the keynote speaker, Dr. Cliff Megerian, UH president, whose presentation was on "Leveraging 'Systemness' for Innovation."

Dr. Megerian said UH is celebrating 154 years of history in Cleveland and shared how they are working on reenvisioning care, related to the pandemic and opioid epidemic.

The following session featured the Attorneys General from Ohio (Dave Yost) and Delaware (Kathy Jennings). Each presenter was asked to describe his and her role in the opioid epidemic, and how the pandemic has changed things this year. Both agreed this year will be the worst for the epidemic. Addiction is tenacious and resources are extremely important, but the pandemic has hindered access to critical resources. Mr. Yost reported that it takes seven attempts at treatment to achieve one year of sobriety. Ms. Jennings stressed that recovery is never a straight line, and a lot still needs to be learned, but comprehensive programs help provide "simple" answers. They also discussed drug courts, and how they assist victims of human trafficking.

Additional concurrent sessions featured alternatives to incarceration in the federal court system for those who are addicted, non-traditional locations for addiction treatment programs, and a Drug Abuse Response Team (DART) in the Lucas County Sheriff's Office in Ohio. AMCNO staff attended the latter session.

The DART program was founded in July 2014 by the current sheriff and features a team of officers who are available 24/7. They are dispatched to local hospitals when overdoses occur, and they engage patients, with the goal of linking them to treatment services. If patients agree to treatment, the team waits until the patients are discharged and then transport them directly to a detox center. If patients decline treatment, the DART team leaves a business card, and places a follow-up call to patients within 72 hours to offer

treatment again. Originally, the county only had 16 detox beds; now, they have 130. They are also now seeing a 79% success rate with the program. An engaging guest speaker talked about his personal success with the program and how he's been sober since 2015 because of it.

The rest of the day's sessions covered topics such as how technology can help understand the evolution of opioid outbreaks and patterns of opioid use; overcoming stigma associated with the addiction; and setting standards for community-based response to drug overdoses (CReDO).

The event then closed with a keynote presentation by Dr. H. Westley Clark, the dean's executive professor of Public Health, Santa Clara University, and board member of the Foundation for Opioid Response Efforts. In summary, Dr. Clark said the information shared during the summit is critically important. Stakeholders, citizens, employers, and so many more, are essential to educate others and promote public health. In addition, trust is crucial for a broad-based effort.

The AMCNO and AMEF will continue to report on and support efforts related to the opioid epidemic, especially during the ongoing pandemic. ■

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AMCNO Announces Staff Promotions

Camera

We are pleased to announce recent staff promotions at AMCNO. Tara Camera has been promoted to Director of Communications. In her new role, Camera is responsible for all external and internal communications for the organization, including the publication of *Northern Ohio Physician*. She has been working with the AMCNO and AMEF since 2014. She is a 1999 graduate of Ashland University, with a Bachelor of Arts degree in Journalism, and a minor in Environmental Science. Outside of work, Camera enjoys volunteering, reading, traveling, and spending time with her friends and family (including her two Labs). She's also a sports fan, especially of the Cleveland Indians and Ohio State Buckeyes.

Yanoska

Valerie Yanoska has been promoted to Manager, Digital Marketing and Membership. In her new role, Yanoska is responsible for developing strategy and overseeing implementation of all digital engagement, member programming and services, and the management of AMCNO's online membership database and website. She has been working with the AMCNO and AMEF since 2018. She graduated from Bowling Green State University in 1995, with a Bachelor of Science in Business Administration. Originally from Northeast Ohio, Yanoska enjoys cheering on Cleveland's many sports teams as well as soaking up the summertime weather. She also enjoys traveling to new places with her family, friends and pet Yorkie. ■

Supreme Court Rules on Outer Time Limit for Filing Malpractice Lawsuits

By Ray Krncevic, Esq., and Elisa Arko, Esq., Tucker Ellis LLP

As we previewed in last summer's issue of *Northern Ohio Physician*, 2020 saw the Supreme Court of Ohio grapple with how long is too long to wait to file a medical malpractice lawsuit. As the year drew to a close, the Court ruled in the twin cases of *Wilson v. Durrani* and *Sand v. Durrani* that a medical malpractice claim cannot be filed more than four years after the alleged wrongful incident. The 5-2 decision establishes that four years is the absolute outer limit, even if the case had once been filed timely and then voluntarily dismissed by a plaintiff.

A quick recap on the facts: Dr. Abubakar Durrani, a Cincinnati-area spine surgeon, was indicted on health care fraud charges for allegedly performing medically unnecessary surgeries, leading to more than 500 civil lawsuits by his patients. The Supreme Court heard cases involving two of those plaintiffs, who had filed timely lawsuits in Butler County, Ohio, but later voluntarily dismissed their cases in late 2015. These plaintiffs refiled their claims a short time later in Hamilton County in an apparent strategic move to get a more favorable pool of jurors, and used Ohio's saving statute, a law that permits plaintiffs to voluntarily dismiss their cases ("without prejudice") and refile them within one year's time. Both plaintiffs refiled well within the one-year timeframe, but appeared to run afoul of a separate law—Ohio's statute of repose. Unlike a statute of limitations, the statute of repose sets an outside four-year limit, with limited exceptions, for malpractice cases to be filed after the alleged negligent event, no matter when the plaintiff discovered the injury. Because the refiling of these two cases occurred more than four years after the plaintiffs' surgeries, the Hamilton County trial court dismissed their refiled claims, citing the statute of repose. The First District Court of Appeals reversed that decision, setting up the showdown at the Supreme Court.

In weighing the dismissal of cases refiled beyond the four-year time limit of the statute of repose but within the one-year time limit of the saving statute, the Supreme Court needed to determine whether the two laws could both be applied consistently with each other, and if not, which law took precedence. Central to this analysis was the legal status of the initial lawsuits filed in Butler County. A 1987 Supreme Court decision, *Frysinger v. Leech*, held that a case refiled under the saving statute "relates back" to the original filing for determining whether the filing was timely under the statute of limitations. But a more recent decision by the Court in 2016, *Antoon v. Cleveland Clinic Foundation*, held that a case dismissed without prejudice "is deemed to have never existed." The justices could not agree on how to resolve the tension between these two precedents.

The majority opinion, written by Justice French, held that the four-year time bar was absolute and could not be extended by saving statute. Noting that the text of the statute of repose recognizes certain specific exceptions (including claims involving minors, persons of unsound mind, and retained foreign objects), the majority held that the lack of an express exception for the saving statute meant that the General Assembly did not intend for the saving statute to be an exception to the statute of repose. In reaching this conclusion, the majority pointed to a different statute of repose (for product liability claims) that did contain an exception for the saving statute, and reasoned that this showed the legislature knew how to enact an exception, and did not intend the saving statute to be an exception to the malpractice statute of repose. The majority emphasized that, given the important goal of protecting defendants from perpetual exposure to liability, any exception must be clearly stated. Finally, relying on *Antoon*, the majority gave no weight to the original filings in Butler County, finding them to have never existed.

Justice Stewart, writing for herself and Justice Donnelly, dissented. In their view, the majority disregarded the longstanding rule in *Frysinger* that, for limitations purposes, a case refiled under the saving statute relates back to the original filing. To them, the intent of the statute of repose—to ensure that defendants did not have to face lawsuits long after the fact—was satisfied in these two cases, because the original filings were well within the statute of repose's four-year limit. Both cases had been significantly litigated, and the refilings came within weeks of the dismissal of the original cases. In other words, the defendants were on notice of these claims—they did not come from out of the blue. In their view, the statute of repose, having been satisfied, was out of the picture, and the one-year deadline of the saving statute was the only relevant time limit in the case.

Assuming the *Durrani* decision stands—as noted below, a motion for reconsideration is pending—it will reaffirm prior rulings that the four-year statute of repose acts as a hard time limit on medical malpractice cases. Moreover, it may cause a plaintiff's counsel to think twice before voluntarily dismissing cases that have been litigated for some time, knowing that the saving statute will not save these cases if the refiling occurs more than four years after the events giving rise to the alleged negligent act. This is good news for litigation-weary physicians in Ohio, and will serve tort reform's ultimate goal that physicians not be priced out of the state by exorbitant malpractice-insurance premiums.

A word of caution is warranted, however. As of this article's writing, and as already noted, plaintiffs have asked the Court to reconsider the decision or to apply it prospectively only. Significantly, Justice French is no longer on the Court, having lost her election to now-Justice Jennifer Brunner. Although reconsideration is rarely granted and unlikely here, the composition of the Court has changed and should the Court revisit this issue in the future, the result may be different. ■

Editor's Note: *The AMCNO had filed a friend-of-the-court brief in support of the defendants. Mr. Krncevic is a member of the AMCNO Medical Legal Liaison Committee.*

The Ohio Supreme Court Clarifies Patient Privacy Issues in the Context of Pursuing Payment of Unpaid Medical Bills in a Collection Lawsuit in *Rolston v. Menorah Park*

By Brian F. Lange, Esq., and Bret C. Perry, Esq.
Bonezzi Switzer Polito & Hupp Co. LPA

The Ohio Supreme Court recently affirmed the dismissal of a Class Action Lawsuit filed by Irene Rolston against Menorah Park Center for Senior Living based on an alleged improper disclosure of protected health information. Initially, Menorah Park filed suit against Ms. Rolston seeking payment of unpaid medical bills and attaching to the Complaint a copy of the medical bills. The medical bills included a short description of the services provided, the date of the service provided, and the cost of each service. Ms. Rolston argued that filing the bill with the court, which included a short description of the medical services rendered, constituted the wrongful disclosure of protected health information. Ms. Rolston further argued that Menorah Park filed similar Complaints against other residents, thereby warranting certification as a class action. The Ohio Supreme Court ultimately rejected the arguments of Ms. Rolston, finding that a medical provider may disclose limited protected health information for purposes of seeking payment for the services, and the submission of limited medical bills with a court in a collection action does not give rise to a state law privacy claim. Accordingly, Ms. Rolston's Class Action Complaint premised on an alleged privacy violation was appropriately dismissed.

The *Rolston* case raises an issue that medical providers in Ohio should be aware of, which is that both federal (HIPAA) and state law govern claims for privacy violations. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is the federal law that governs the disclosure of protected health information. The Department of Health and Human Services is tasked with enforcing HIPAA, and any potential violations of HIPAA may result in a fine being issued. With that said, a potential violation of HIPAA does not give rise to a civil lawsuit because HIPAA cannot be enforced in court. In contrast, Ohio provides an avenue by which an individual may pursue a private civil lawsuit for the unauthorized and unprivileged disclosure of protected health information. Specifically, the Ohio Supreme Court acknowledged a claim for compensatory damages in the case of *Biddle v. Warren General Hospital* (1999) for an improper disclosure of protected health information. At the time the Court ruled in *Biddle*, HIPAA had not yet been enacted. Given the *Biddle* case, an Ohio medical provider could be subjected to fines for violation of HIPAA through the Department of Health and Human Services, as well as a claim for damages in a lawsuit filed in Ohio State Court. The damages associated with such a claim are case specific and a Plaintiff must establish that the disclosure of protected health information at issue caused the Plaintiff some actual damage, which could be emotional distress.

Given this discrepancy, the Ohio Supreme Court in *Rolston* considered whether to eliminate the state law claim for the unauthorized and unprivileged disclosure of protected health information, as HIPAA provides specific rules governing the disclosure of protected health information. In fact, HIPAA includes a specific rule addressing the disclosure of protected health information for purposes of seeking payment, which was applicable to the disclosure made by Menorah Park. Specifically, HIPAA includes a "minimum necessary" standard as it relates to seeking collection of medical bills, which means a provider should disclose no more than the "minimum necessary" information to collect on the bill.

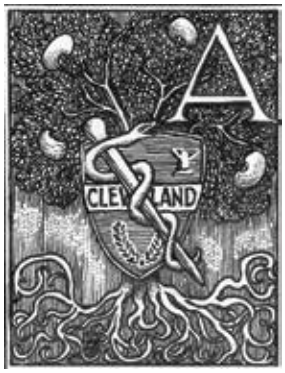
Plaintiff Rolston argued that this "minimum necessary" standard meant the provider should have redacted the protected health information from the bill submitted to the court, leaving only the individual's name and the amount due. Menorah Park argued that they were required to submit the bill to support the claim, and by not attaching the medical records associated with the services that Menorah Park disclosed the "minimum necessary." Menorah Park also argued that given the implementation of HIPAA, which governs privacy concerns as it relates to a patient's protected health information, and includes monetary fines, there no longer existed a need for a state law claim for privacy violations, and the Ohio Supreme Court should eliminate such a claim.

In reaching its decision, the Ohio Supreme Court ruled in favor of Menorah Park, finding that the bill submitted to the court, which included a short description of the service rendered, was the "minimum necessary" and, as such, Ms. Rolston's Class Action Claim should be dismissed. However, the Ohio Supreme Court was not willing to eliminate Ohio's state law privacy claim and, as such, medical providers will continue to be subject to both HIPAA violations as well as the possibility for a state lawsuit.

While the Supreme Court ruled in Menorah Park's favor, the Ohio Supreme Court seemed divided on this issue. As such, best practices when pursuing payment for unpaid medical bills in court would be to redact all information that could be considered medical in nature, including any description of the service rendered, leaving only the patient's name and the amount due. If these redactions are made, it will likely protect against the potential for any claimed HIPAA violation or state law privacy complaint. ■

Editor's Note: *The AMCNO had filed a friend-of-the-court brief in this case.*

Help Us Choose a New Logo!



As we move forward as an organization under new leadership, the AMCNO is in the process of re-branding, including creating a new website and logo.

Be part of the process and help us choose our logo! From the two options, select the one you would like to see the Academy carry into the future. Both images take inspiration from the Academy of Medicine's first logo, shown at left.

Which new logo do you think best represents our organization, our community, you as a member? To cast your vote, visit our survey at tinyurl.com/AMCNOvote. **The voting deadline is March 15.**

Please stay tuned as we keep you updated on the progress of the exciting changes currently underway at the AMCNO, including our new and improved website and online membership management system. And please be on the lookout for more information about our website launch party sometime this summer! We are looking forward to hosting you, as we work hard to maintain the goal of serving our members in the best way possible.

AMCNO President Dr. Thomas Collins Testifies on Interstate Licensure Compact

(Continued from page 1)

The mission of the compact is to increase access to health care—particularly for patients in underserved or rural areas. The agreement makes it possible to extend the reach of physicians, improve access to medical specialists, and leverage the use of new medical technologies, such as telemedicine. And because of the COVID-19 epidemic, the demand for virtual health care has risen substantially.

Before physicians can participate in the compact, they must designate an SPL, complete an application, and then receive a formal Letter of Qualification from that state, verifying that they meet the compact's strict eligibility requirements. Physicians cannot obtain licenses through the compact without completing these steps. The AMCNO believes these protections will help ensure safe, quality care for all Ohioans.

The AMCNO is currently working with a coalition of proponents to advance this legislation, including the Ohio State Medical Association, Cleveland Clinic, University Hospitals, Akron Children's Hospital, Summa Health and the Ohio State University Wexner Medical Center. ■

Return on Investment: Medicaid's Impact on Kids

By Loren Anthes, MBA, The Center for Community Solutions

The biennial budget is perhaps the most comprehensive and consequential policy document in Ohio state government. During the budget process, lawmakers must balance the state's policy goals against the realities of limited resources and competing needs. With the economic and health impacts of COVID-19, an incoming Biden administration and Democratic majority in Congress, **Ohio's 134th General Assembly will face tough choices as members manage the new political and policy landscapes of the 2021 budget cycle.**

Representing more than 40 percent of the budget, Medicaid plays a central role as a source of coverage for 1 in 4 Ohioans. It is also a key financial tool to make the budget whole and a critical foundation for Ohio's economy. But for all the investment, what is the return on that investment (ROI)? Does Medicaid improve health outcomes, lower costs and create better economic opportunities for enrollees?

While we have looked into these questions around rural communities and how Medicaid supports the state budget, we have not examined how Medicaid can produce returns in regard to children. This piece does so by examining relevant evidence-based literature and putting forward empirical data therein for policymakers, advocates and media members to consider.

Findings from the literature are summarized below. Additionally, detail is provided by research papers in tables (to the right), with categories that define the ROI of Medicaid coverage for children.

FINDINGS

1: Produces Better Health Outcomes

The literature provides evidence of significant improvement in outcomes in a number of ways. **Children who are covered early in life are more likely to use preventive care and are healthier as adults.** This means they have better outcomes associated with chronic diseases, immunity disorders and mortality. Interestingly, Medicaid coverage also yields better intergenerational health for children born to individuals covered by the program in early life.

CHILDHOOD MEDICAID COVERAGE AND LATER-LIFE HEALTH CARE UTILIZATION[1]		
RETURN ON INVESTMENT FACTORS	Outcomes	More years of childhood eligibility are associated with fewer hospitalizations in adulthood. The effects are pronounced for utilization related to chronic illnesses and for patients living in low-income ZIP codes.
	Costs	Calculations suggest that lower rates of hospitalizations during one year of adulthood for Blacks offset between 2 and 4 percent of the initial costs of expanding Medicaid for all children.
	Economic Mobility	For Black enrollees, a 7 to 15 percent decrease in hospitalizations and a suggestive 2 to 5 percent decrease in emergency department visits.

THE EFFECT OF CHILD HEALTH INSURANCE ACCESS ON SCHOOLING: EVIDENCE FROM PUBLIC INSURANCE EXPANSIONS[2]		
RETURN ON INVESTMENT FACTORS	Economic Mobility	Analyzing data from the 1980s and 1990s, expanding health insurance coverage for low-income children increases the rate of high school and college completion and general educational performance. Among nonwhites, the effects on high school noncompletion are larger, where noncompletion was reduced by 0.46 percentage points for each 10-percentage point increase in Medicaid eligibility.

THE LONG-TERM EFFECTS OF EARLY LIFE MEDICAID COVERAGE[3]		
RETURN ON INVESTMENT FACTORS	Outcomes	Those whose mothers gained eligibility for prenatal coverage under Medicaid have lower rates of obesity as adults and fewer hospitalizations related to endocrine; nutritional and metabolic diseases; and immunity disorders as adults. There are particularly pronounced reductions in visits associated with diabetes and obesity.
	Economic Mobility	Prenatal expansions improved educational and economic outcomes for individuals, and individuals who gained Medicaid eligibility in utero have higher high school graduation rates and higher incomes in adulthood.

THE LONG-TERM IMPACTS OF MEDICAID EXPOSURE IN EARLY CHILDHOOD: EVIDENCE FROM THE PROGRAM'S ORIGIN[4]		
RETURN ON INVESTMENT FACTORS	Outcomes	Medicaid coverage in childhood found that gaining Medicaid eligibility from age five through 18 is associated with improved contemporaneous utilization of preventative care.
	Economic Mobility	The introduction of Medicaid was associated with a reduction of the probability of having any household debt.

EARLY-LIFE MEDICAID COVERAGE AND INTERGENERATIONAL ECONOMIC MOBILITY[5]		
RETURN ON INVESTMENT FACTORS	Economic Mobility	Increasing the proportion of low-income pregnant women eligible for Medicaid improved the upward economic mobility outcomes of their children in adulthood.

2: Lowers Costs Inside and Outside of Health Care

Children covered by Medicaid are not only less likely to suffer from expensive chronic diseases later in life, they are also less likely to be hospitalized. However, the positive economic impacts are not just relegated to health spending. When children have access to Medicaid coverage, they are less likely to need Social Security Disability Income and less likely to collect Earned Income Tax Credit (EITC) payments.

3: Increases Economic Mobility

Not only does coverage improve the ability of children born into poverty to escape the cycle of poverty, it also has been shown to reduce economic racial disparities. This is not only represented by higher earnings later in life, but also through better educational outcomes, including higher completion rates for high school and college. Beyond the direct impact, Medicaid also enables households to be more financially secure, with access to Medicaid coverage resulting in less debt, generally. ■

MEDICAID AS AN INVESTMENT IN CHILDREN: WHAT IS THE LONG-TERM IMPACT ON TAX RECEIPTS?[6]		
RETURN ON INVESTMENT FACTORS	Costs	Children whose eligibility increased paid more in cumulative taxes by age 28. These children collected less in EITC payments, and the women had higher cumulative wages by age 28. The government will recoup 56 cents of each dollar spent on childhood Medicaid by the time these children reach age 60, though for every year of Medicaid eligibility from birth to age 18 results in approximately 0.58 additional years of Medicaid receipt, meaning results are likely almost twice as large.

CONTEMPORANEOUS AND LONG-TERM EFFECTS OF CHILDREN'S PUBLIC HEALTH INSURANCE: EXPANSIONS ON SUPPLEMENTAL SECURITY INCOME PARTICIPATION[7]		
RETURN ON INVESTMENT FACTORS	Costs	In the long term, increased public insurance eligibility during childhood reduces young adult Social Security applications and awards.

SAVING TEENS: USING A POLICY DISCONTINUITY TO ESTIMATE THE EFFECTS OF MEDICAID ELIGIBILITY[8]		
RETURN ON INVESTMENT FACTORS	Outcomes	The estimates indicate a 13-20 percent decrease in the internal mortality rate of Black teens born after September 30, 1983.
	Economic Mobility	Our analysis shows that Black children were more likely to be affected by the Medicaid expansions and gained twice the amount of eligibility as white children.

ACCESS TO THE SAFETY NET: EARLY LIFE EXPOSURE TO MEDICAID AND THE NEXT GENERATION'S HEALTH[9]		
RETURN ON INVESTMENT FACTORS	Outcomes	Robust evidence that health benefits associated with generations' early-life access to Medicaid extend to later offspring's birth outcomes. For birth weight outcomes, the estimated effects of in utero eligibility are about 10 times as large as the estimated effects associated with one additional year of eligibility later in childhood.
	Spending	Eligibility is associated with a reduction in the probability of a subsequent low-birth weight birth of about 0.005, resulting in approximately $250 ($50,000 x 0.005) in savings per woman made eligible. Medicaid eligibility under the targeted expansions generated an increase in annual personal income of 20 percent between ages 23 and 36, or approximately $5,974 (2009$s).
	Economic Mobility	Medicaid expansions also improved early and later life health by reducing family medical spending and freeing up resources for other types of family investment.

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FAQs About COVID-19 Vaccinations

By The Doctors Company

As healthcare providers prepare to distribute COVID-19 vaccines, many face questions regarding best practices for vaccine administration, as well as documentation. Answers to the frequently asked questions below will help your practice protect patients and staff while mitigating liability risks.

What possible malpractice risks do I face in providing the COVID-19 vaccine?

Numerous states have granted healthcare providers and facilities limited temporary protections from liability for treatment provided in relation to the public health emergency, and the U.S. Department of Health and Human Services expanded the scope of the PREP Act immunity to potentially cover more healthcare providers who administer the vaccine or where not administering a vaccine is a covered countermeasure for certain individuals. However, patients can still make claims. Based on previous vaccination-related claims, the following are some potential risk scenarios:

- Due to lack of follow-up by the medical practice, a patient misses their second dose, contracts the virus, experiences an adverse event, and files suit.
- A patient who isn't adequately monitored after being given the vaccine faints and is injured in the fall or experiences an allergic reaction.
- No informed consent is obtained, and the patient experiences a severe complication, interfering with their ability to work. The patient states they would never have had the injection had they known of the potential complications.
- Informed refusal is not obtained, and the patient then claims they were unaware of the risks of not taking the vaccine. The Doctors Company provides a Refusal to Consent to Treatment, Medication, or Testing form.

How can I reduce the chance of a malpractice suit when administering the COVID-19 vaccination?

Consider taking the following steps to enhance patient safety and avoid medical malpractice risks:

- Screen patients for contraindications and precautions prior to administering the vaccine to prevent adverse events following vaccinations.
- Educate patients regarding vaccination schedules.
- Designate a staff member to monitor for revisions and/or new recommendations from the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC).
- Provide written educational materials to patients in their preferred language (e.g., vaccine information sheets). Conduct and document a thorough informed consent discussion using language the patient can understand. Include information on the potential consequences of contracting the disease as a result of non-vaccination.
- Use a vaccination informed consent form, and document the consent discussion in the medical record.
- Educate staff and conduct skills verification on accepted procedures, new standards, and risk prevention methods. Document these efforts in administrative training files.
- Store and handle vaccinations in accordance with manufacturers' guidelines. Monitor these practices with staff—don't just assume they are being followed correctly.
- Follow basic medication administration safety protocols for vaccine administration. Be aware of the most common vaccine-related errors by reviewing "Confusion Abounds! 2-Year Summary of the ISMP National Vaccine Errors Reporting Program" Part I and Part II.
- Should an error in vaccine administration occur, conduct a disclosure discussion with the patient/parent utilizing The Doctors Company's Disclosure Resources. Conduct a root cause analysis with your staff to determine why an error occurred and to prevent reoccurrence in the future by adjusting office procedures and providing staff training, as needed.
- Be responsive to patients who express concerns about reactions to their vaccines. Document these discussions in the medical record.
- Ensure all vaccines are entered into the specific state vaccine monitoring program.
- Have a follow-up and tracking system to ensure patients receive the second vaccination. Document all follow-up communications with patients in the medical record.
- Educate patients on the potential side effects of the vaccine, which include fever, pain at the injection site, muscle aches, fatigue, headaches, and chills.

Where can I get information on how the vaccine will be distributed in my state?

The CDC provides links to each state's vaccination program executive summary. These serve as interim playbooks for states, territories, tribal governments, and local public health programs to operationalize the COVID-19 vaccination plan. Each state and territory has adopted more specific documents, to be found at the jurisdiction's department of health websites, often noted in the plan summaries.

Once the vaccine is being administered, how long do I have to continue to supply personal protective equipment (PPE) to my staff?

Physicians should continue to require appropriate PPE for all staff until the national vaccination rate meets CDC guidelines (expectation is the third quarter of 2021). Follow CDC guidelines for recommended use of PPE in the clinical setting.

What do I do when a patient does not return, or refuses to return, for their second dose of the vaccine?

The following can reduce your risk:

- Document the refusal and why the patient doesn't want to return.
- Follow up with a certified letter and telephone call to remind the patient of the need to return.
- Place a copy of the letter and its receipt along with documentation of the telephone call in the patient's record.
- Remind the patient that the efficacy of the vaccine is significantly reduced if not followed with the second vaccination.

How do I get my office ready for the vaccine?

The CDC provides advice on vaccine storage and handling best practices, a training module for healthcare professionals, and reference material in the COVID-19 Vaccine Training Module for Healthcare Professionals.

For CDC information specifically addressing the Pfizer-BioNTech COVID-19 vaccine and Moderna vaccine: Interim Clinical Considerations for Use of mRNA COVID-19 Vaccines Currently Authorized in the United States.

The FDA's Fact Sheet for Healthcare Providers Administering Vaccine (Vaccine Providers) gives information on vaccine administration, safety, storage, informed consent, and reporting adverse events specific to the Pfizer vaccine.

For information specifically addressing the Moderna COVID-19 vaccine, see Moderna's Work on a COVID-19 Vaccine Candidate.

What should I do about patients who refuse to be vaccinated or refuse to return for a second required dose?
It is a physician's obligation to talk with all patients (or their guardians) about what could happen if they decline vaccination. Consider the following when having a discussion with the patient:

A successful and safe vaccination campaign will be an important step in lowering public health risks associated with this pandemic. Tell patients that vaccines don't save lives—vaccination does.

Inform patients that even if they are vaccinated, they need to continue the safe practices recommended by the CDC. Currently, the Pfizer vaccine has been shown in clinical trials to be 95 percent effective, but vaccinated people can still get the virus (not from the vaccine, but acquired in the community), perhaps with fewer symptoms—so they may not realize when they are infected. Thus, they may spread the virus to others. Until we have achieved "herd" immunity, all individuals, regardless of vaccination status, will still need to continue the practices of appropriate masking, social distancing, and handwashing. If there is contact with a known positive individual, the vaccinated individual should follow the current CDC guidelines for testing and quarantine.

What should I do if a patient experiences an adverse event following administration of a COVID-19 vaccine?
Ensure that your clinic is prepared for anaphylactic reactions prior to administering the vaccine (e.g., stock epinephrine prefilled syringes, H1 antihistamines such as diphenhydramine, blood pressure cuffs, stethoscopes, a wristwatch or other timing device, and oxygen; ensure 911 accessibility). Supplies might also include (though the following are not required) pulse oximeters, oxygen, bronchodilators (such as albuterol), H2 antihistamines (such as famotidine, cimetidine), IV fluids, intubation kits, and adult pocket-sized masks with one-way valve for CPR). The CDC provides guidance at Interim Considerations: Preparing for the Potential Management of Anaphylaxis at COVID-19 Vaccination Sites.

Keep in mind that Phase 3 trials are not complete in all cases, and the population studied was limited in the interim analysis. Therefore, before an adverse event occurs, read more from the FDA's fact sheet for administering vaccines. On page 8, you will find instructions for submitting a report to the Vaccine Adverse Event Reporting System (VAERS) by text or phone.

Will my medical malpractice insurance cover me in case of an adverse event related to administering a COVID-19 vaccine?
Most likely. We must approach each claim based on its facts, and coverage cannot be guaranteed in every case—for instance, we cannot defend a member who has broken the law. That said, members acting in good faith and within the best community standards of care should not have additional anxiety on this point. We stand behind our members as they practice good medicine during this unprecedented public health crisis.

Where can I find additional resources on the COVID-19 vaccine?
The American College of Physicians has put together an extensive guide and resources for you. It provides "expanded planning and implementation resources to include guidance on mitigation of post-vaccination symptom effects on staffing; resources to build vaccination confidence; reimbursement links; a second dose tracker link; FAQ links; guidance for recommending vaccines to patients, and fact sheets for patients."

What liability protections do I have when administering the vaccine?
In 2005, Congress passed into law the Public Readiness and Emergency Preparedness Act, commonly referred to as the PREP Act. The PREP Act provides limited legal liability in order to facilitate the development and implementation of medical countermeasures during a federally declared public health emergency and has been recently amended to provide immunity to providers who administer the COVID-19 vaccine, in addition to other clarifying directives.

The PREP Act provides "liability protections to certain individuals and entities (Covered Persons) against any claim of loss caused by, arising out of, relating to, or resulting from, the manufacture, distribution, administration, or use of certain medical countermeasures (Covered Countermeasures), except for claims involving 'willful misconduct' as defined in the PREP Act."

On Dec. 3, 2020, former Secretary Azar declared that liability protections will be afforded to those Covered Persons who "manufacture, test, develop, distribute, administer, or use" the COVID-19 vaccine. The liability protections were triggered when the vaccine itself was defined as an approved Covered Countermeasure. In addition, the scope of the PREP Act was clarified to acknowledge that there are situations when not administering a Covered Countermeasure is appropriate and can fall within the Act's liability protections.

For purposes of administering the COVID-19 vaccine, the amended declaration includes in its definition of Covered Persons as persons who are authorized under law to "prescribe, administer, deliver, distribute or dispense" the vaccine and includes pharmacists who meet specific training requirements.

The liability protections for COVID-19 vaccine countermeasures began on Dec. 3, 2020, through the final day of the federally declared emergency or Oct. 1, 2024, whichever date is first.

The law and its broad application were relatively obscure until the advent of the COVID-19 pandemic when, on March 17, 2020, former U.S. Department of Health and Human Services (HHS) Secretary Alex Azar issued a declaration under the Act to provide limited immunity for countermeasures necessary to combat the virus.

Since then, four amendments to the declaration have been issued to clarify what countermeasures and covered persons are under the Act's limited liability umbrella ranging from the use of telehealth to respirators. ■

Issues Related to the COVID Vaccine in Women

By Dr. Mary LaPlante, AMCNO Member

As vaccine distribution is ongoing, we as physicians are addressing many of our patients' concerns regarding vaccine safety. One group of especially concerned patients are women who are pregnant, breastfeeding or contemplating pregnancy.

The Maternal Immunization Task Force issued a statement on Feb. 3, 2021, that supports offering the COVID-19 vaccine to all pregnant and lactating women who meet criterion. Additionally, it opposes denying these women the opportunity to be vaccinated. The American College of Obstetricians and Gynecologists (ACOG) endorses protection of the patient's right to autonomy. Discussing the risks of vaccination and not being vaccinated with their care team is strongly encouraged. While pregnant and lactating women were not enrolled in the study populations during the development of the COVID-19 vaccine, more than 20 women in either the Pfizer or Moderna vaccine trials became pregnant and are being monitored. Due to the nature of the vaccine, it does not cross the placenta. No adverse outcomes have been identified. With many women employed in health care, more than 8,000 pregnant women have been vaccinated.

We do know that pregnant women who become symptomatic from COVID-19 have worse outcomes. They are more likely to be admitted to the ICU or need ventilator support. Current data shows that the benefits outweigh the risks of receiving the COVID-19 vaccine in pregnant and lactating women. Encouraging enrollment in the CDC V-safe program will provide valuable data for ongoing safety monitoring.

Some women are choosing to defer the COVID-19 vaccine until after the first trimester. Currently, there are no known risks to receiving the vaccine during early pregnancy; however, this decision should be between the patient and their physician or care provider.

Vaccine hesitancy often surrounds false information. Subsequently, women have presented concerns regarding false information that the vaccines are linked to infertility. There is no evidence to support these claims, and scientifically it is unlikely. Subsequently, women who are attempting to conceive should not defer the COVID-19 vaccine.

Vaccination is vital in combatting the COVID-19 pandemic. Having an open conversation is our best defense against vaccine hesitancy. ■

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- CDC V-safe after vaccination health checker https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html
- American Society of Reproductive Medicine COVID-19 Updates and Resources https://www.asrm.org/news-and-publications/covid-19/

COVID Vaccination Resources for Physicians

We sincerely appreciate our members and all physicians for their tireless efforts during the COVID-19 pandemic.

In our continuing effort to provide you with the latest information, following are updates concerning the COVID-19 vaccination rollout.

If you are a physician who has not already received a vaccine, you'll need to register with the Cuyahoga County Department of Health at https://www.ccbh.net/vax/. You can also sign up for an email list there that will let you know when more vaccines are available, should you wish to host a clinic at your practice for your patients. If you need to call the Cuyahoga County Board of Health, the number is (216) 201-2000.

A comprehensive COVID-19 resource list is available on our website, but we would like to highlight these resources:

- The main page for vaccinations on the Ohio Department of Health website: https://coronavirus.ohio.gov/wps/portal/gov/covid-19/covid-19-vaccination-program
- The American Medical Association's resource center for physicians: https://www.ama-assn.org/delivering-care/public-health/covid-19-2019-novel-coronavirus-resource-center-physicians

As of press time, Ohio is in Phase 1B, which includes Ohioans who are 65 years of age or older; those with a developmental or intellectual disability AND born with or who have early childhood conditions that are carried into adulthood; employees of K-12 schools who wish to remain or return to in-person or hybrid models; and Ohioans born with or who have early childhood conditions that are carried into adulthood that put them at higher risk for adverse outcomes due to COVID-19.

If you have any questions or need further assistance, please contact AMCNO Executive Director Jen Johns at (216) 532-4505 or via email at JJohns@amcno.org. ■