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Two Years into ACA Implementation Regional Patterns of Uninsured Emerge

Recently, the New York Times published a geographical analysis of those Americans who remain uninsured two years after the implementation of the individual mandate and state-based insurance exchanges under the ACA[1]. Summary: for the most part, they live in the South and they are poor.

Rates of uninsured have fallen into single digits in the Northeast and the Midwest since the ACA went into effect, but primarily in the South and Southwest significant numbers of Americans remain without health insurance. This despite the fact that Arkansas and Kentucky lead the way with the biggest decreases in their uninsured rates since 2014. In the second year of analysis of the law's impact, the decrease in uninsured was much less dramatic than in 2014, but in states like Pennsylvania and Indiana, where Medicaid expansion had been delayed, substantial drops in the uninsured population occurred in 2015. In Mississippi, the situation got worse with more people uninsured in 2015 than the previous year.

Seven states had achieved uninsured rates at or below 5% by the middle of 2015: Connecticut, Iowa, Hawaii, Massachusetts, Minnesota, Rhode Island and Vermont. Previously, only Massachusetts had reached that level for the period 2008-2014.

Data shows that fewer people signed up for coverage on the state exchanges in 2015 than had been expected and Medicaid enrollment leveled off nationally. More than 3 million people in 19 states that have refused to expand Medicaid remain in a "Medicaid gap". States with large remaining populations of uninsured are primarily those that have forgone expansion, thus preventing many of their low income citizens from benefiting from ACA programs. They remain too poor to qualify for subsidies limited to those with incomes above the Medicaid expansion target (138% of the federal poverty level) while not poor enough to qualify for their state's Medicaid program.

"This year it's more of a state-specific story," according to Enroll America director of data and analytics Ed Coleman. "There was a pronounced drop pretty much everywhere last year, and we don't see that pattern again this time around."

Overall, Republican leaning states have more uninsured people than Democratic leaning states. These same states tended to have more uninsured people to begin with prior to implementation of the ACA. Medicaid expansion has become a major predictor of the level

Legislative Night 2016. . . Page 3

of uninsured in a given state. Seven of the 10 states with the largest drops in uninsured rates both expanded Medicaid and established state exchanges, while two others implemented one or the other. Expansion plans are still being considered in a few more states. Alaska began its expansion in September 2015, and Montana is moving toward expansion in 2016, making 30 states that have adopted expansion plans. Kentucky's future is unclear following the recent election of a Republican governor who has signaled his interest in pulling back on already implemented expansion there.

It seems that the goal of the ACA when it passed to provide health insurance coverage to an estimated 32 million people may not be reached with the current approaches. Incomplete Medicaid expansion, the result of the 2012 Supreme Court decision leaving expansion up to the states, and less than anticipated participation in the marketplace exchanges may require new strategies to expand coverage. Estimates made in 2010 by the Congressional Budget Office predicted 8 million people would buy exchange plans in 2014, and 21 million in 2016. Actual figures show 6.3 million enrolled by the end of 2014, and HHS figures released in November project 10 million will be enrolled in 2016. On a positive note, more people have maintained employer-based coverage than originally predicted by the CBO.

The ACA has clearly had a substantial positive impact on uninsured rates across the country. Recent data from Gallup[2] shows the national rate at 11.6% in the third quarter of 2015, down 5.5% from the fourth quarter of 2013 before the ACA individual insurance mandate took effect in 2014. This is the lowest rate recorded in 50 years. The greatest drops occurred among racial and ethnic minorities and low-income populations. Among Hispanics, the uninsured rate has dropped 9.7% since 2013, and among African-Americans it has dropped 7.5%.

According to the Colorado Health Institute, Colorado's rate of uninsureds has dropped from 14.3% in 2013 to 6.7% in 2015 based on results from their Colorado Health Access Survey completed in Spring 2015. Some other surveys report differing rates for Colorado as high as 11.2% based on different survey methodologies and timing.

As data accumulates revealing the different ACA outcomes in each state and region across the country, we are likely to see new strategies develop to build on the success so far.

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[1] *By Quoctrung Bui and Margot Sanger-Katz, **The New York Times**, Oct. 30, 2015.*
[2] *By Stephanie Marken, **Gallup**, October 8, 2015.*

To access the links in the Bulletin, go to the DMS website—denvermedsociety.org—and open the Denver Medical Bulletin page.

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Metropolitan Medical Society
Legislative Night 2016

Wednesday, February 3, 2016

6:00 – 8:00 pm

Cocktails and Hors d'oeuvres

Warwick Hotel – Millennium Ballroom

1776 Grant Street, Denver

The Denver, Arapahoe-Douglas-Elbert, and Aurora-Adams County Medical Societies, in conjunction with the Colorado Medical Society, are proud to team up and present a night of informal discussions with our Denver Metro State Legislators. We hope you will take advantage of this opportunity to meet some of your legislators and offer your insight on hot issues this legislative session like health plan networks, parity for Medicaid rates, administrative burdens placed on physician practices and proposed health plan mergers. Legislators will face enormous challenges in addressing these issues in the coming legislative session and they need to hear from you!

**In order for us to best prepare for this evening,
reservations are required no later than Friday, January 29th.**

RSVP by email to info@denvermedsociety.org, call us at 303-377-1850, or fax your reservation to 303-331-9839. Please give us your name and specialty when you RSVP.

Name _____ Specialty _____

Overcoming the Stress of Malpractice Litigation
Solutions to Help Physicians Stay Healthy and Engaged

Imagine the scene: You're in your busy office on a typical day when a letter arrives—a letter of intent. A patient is suing you for malpractice.

From the moment you receive that letter, everything changes. The malpractice claim begins to affect all aspects of your life. You don't sleep well. You don't interact well with family members, friends, or colleagues. You remain dedicated to providing the best possible care, but you find yourself taking a more conservative approach with patients, asking yourself, "How might this patient attempt to sue me?" Or, "If I were standing in front of a judge, what evidence would I need to defend what I'm doing?" You know you did nothing wrong—that the claim against you is unreasonable—which only adds to your frustration and sense of injustice.

If the lawsuit proceeds to trial, you'll face the uncertainty that accompanies any courtroom process. And that process can be lengthy, dominating your personal and professional life for a year, two years, or more.

For most doctors, this scenario will play out at least once during their career. In fact, a typical doctor spends nearly 11 percent of a 40-year career with open malpractice claims.[1] Facing a medical malpractice lawsuit will almost certainly be one of the most trying experiences you encounter as a physician, adding to the pressures of an already demanding profession. The lawsuit will generate an array of negative emotions, from self-doubt to high levels of stress and anxiety. But as I learned during my own litigation experience, there are steps you can take to ease the strain you're under and limit these symptoms, allowing you to continue to serve your patients and maintain healthy relationships with those around you.

Prepare Thoroughly

First, take a deep breath—and then prepare. Approach the lawsuit simply as an unfortunate consequence of practicing medicine, the price of being a physician. In today's medical climate, a lawsuit is essentially inevitable, especially if you conduct procedures. Treat the litigation as another necessary part of your career, and take the same approach as you would toward other hurdles like a board exam. Be meticulous. Go over your chart. Familiarize yourself with every aspect of the case. Be ready for your meetings with your attorney, and take an active role in your defense.

If you go to trial, the plaintiff's attorney will make every effort to belittle you, anger you, and make you question yourself. When I took the stand, the plaintiff's attorney attempted several techniques to unnerve me, even using his physical stature to try to intimidate me as I sat in front of the jury. He tried to chip away at my reputation, and he sought to create in the minds of the jurors the expectation that every case should have a perfect outcome.

Remember, in that situation, no one in the room knows the case better than you. Approach your testimony the same way you approach a talk at a conference—you are the expert, the master of that topic. This is your case, and you took care of the patient. That will reinforce your confidence and help you stay calm in the face of aggressive questions from the opposing attorney.

Above all, prepare for the witness chair by taking part in litigation education, especially a mock deposition. During the mock deposition I participated in, the attorney asked me the same types of questions and adopted the same approaches I would later face at trial. We were then able to evaluate my responses on video. My eyes were opened to what I could expect from a trial—I got deep insight into the real nuts-and-bolts mechanics of it. That helped me prepare for the moment when the plaintiff's attorney would challenge me. I referred to my notes from the training prior to my deposition and prior to going on the stand during trial. This was a huge stress reliever. You can't lose your cool on the stand, and falling back on those techniques helped me stay calm.

Reach Out

When confronted with a malpractice claim, doctors experience anger and embarrassment. These are natural reactions. Doctors are often reluctant to talk about past litigation because they're afraid it reflects poorly on them—fearful that somebody will feel they did something wrong. To ensure defensibility, physicians will wisely

MEDICAL SPANISH AND CULTURAL COMPETENCY CLASS

Friday, April 22 - Monday, April 25, 2016

8:00 AM to 5:00 PM

Denver Medical Society

1850 Williams Street, Denver

Colorado has one of the highest proportions of Hispanic and Latino populations in the country. Denver counts over 31% of its population in this category! To enhance physician communication capabilities, Denver Medical Society in conjunction with the Community Health Association of Mountain/Plains States (CHAMPS) is offering a 4 day intensive, total -immersion learning experience in conversational and medical Spanish for physicians, nurses, PAs, NPs and other medical staff. Class levels are targeted to each student's needs and abilities. This is the 20th offering of this lively, rewarding, and highly popular class conducted by Rios Associates.

Four day class offers a ton of CMEs! Plan now to attend.

45 prescribed hours by the American Academy of Family Physicians (AAFP)
43 hours of Category 1 CME from the American College of Emergency Physicians (ACEP)
45 contact hours of continuing education by the American Academy of Nurse Practitioners (AANP)
43 hours of Category 1 CME from the American Medical Association (AMA)

The cost of the class, including text book: **$549 for DMS members**
$699 for non-members

Morning and afternoon snacks are provided.

To register, **call Tamara Rios directly at (520) 907-3318. Please call Tamara at that number or email her at convesp@aol.com if you need additional information.**

avoid discussing an ongoing claim with anyone other than their claims specialist or defense attorney. But after my litigation was over, whenever I brought it up to other physicians—even speaking in general terms—I could sense their discomfort and unwillingness to acknowledge their own past litigation experiences. This was especially true in group settings. However, it can be a huge benefit if you can find a colleague willing to share: a person you respect and are comfortable with, someone who has battled a malpractice claim themselves. A colleague can offer advice and expertise on how to move forward from your ordeal.

Talking with your family is another vital step. The impact on family members can be substantial. During my litigation, over Christmas break our dining table resembled a war room, covered with multiple computers and an array of charts and other materials. I'd meet with my defense attorney at home, and I'd often wake up at 4:00 AM so I could review the 8,500-page medical record. Because of the length of my litigation, this significantly impacted my family over two successive Christmases—times when I wasn't really there for them emotionally.

Although you can't divulge the clinical details of a current claim to family members, you can talk with them about how it is affecting you. By opening up to your spouse, children, and other family members, you can help prepare them and ease your own burden. Be completely open about what's happening and how it could impact both you and them. Seek their input and advice. This can help you overcome the feelings of isolation that often accompany a malpractice claim. Doctors often have a tough, go-it-alone mentality. But this is the bottom line: Don't go into a shell. Talk to somebody.

Make Yourself a Priority

Every profession has its stresses, but doctors' stresses are unique. Overwhelmed patients share with us their innermost thoughts and concerns. Faced with difficult decisions—sometimes those that are life-and-death—they trust our expertise and rely on us to always take the right action. Added to that is the stress of delivering bad news, something I frequently encounter in my role as a gynecologic oncologist. I often need to tell patients that their lifestyle decisions are harming them, a message that isn't always well received. And while many of my patients do well, I need to tell some that cancer will ultimately take their life, even if their outcome is positive in the short term. Depending on your personality, these interactions can be incredibly draining.

To these everyday stresses of our profession, add the stress of fighting a lawsuit to defend your reputation—more than ever, it becomes imperative that you take care of yourself. Don't hesitate to make yourself your first priority. Do whatever you need to do to unwind. This might be physical exercise like running or biking, or it might simply involve becoming more engaged in other personal interests. If you're not blocking out time to decompress, you're doing a disservice to yourself, your case, and your patients.

Rising Above the Challenge

Ultimately, after two trials spanning two-and-a-half years, I was completely exonerated by the jury. I was thrilled with the outcome, but I had endured a long period in which my personal and professional relationships were impacted. Having never been sued before, I found it very difficult to handle being accused of doing something wrong. But the emotional toll could have been much worse. By adopting certain strategies, I was able to mitigate many of the negative effects so many doctors experience. Litigation will inevitably be an intense and challenging experience, but you can avoid it becoming a crisis. You can still maintain your self-assurance, keep your relationships intact, and continue to provide the vital medical care on which your community relies.

By David P. Michelin, MD, MPH, a gynecologic oncologist in Traverse City, Michigan.

Contributed by The Doctors Company

Reference

1. Seabury SA, Chandra A, Lakdawalla DN, Jena AB. On average, physicians spend nearly 11 percent of their 40-year careers with an open, unresolved malpractice claim. *Health Affairs*. 2013;32(1):111–9.

New Grant Opportunities Available for Qualified Practices in Colorado

There are new healthcare grants available to Colorado practices offered by the State of Colorado and other sources. Colorado physician practices and medical clinics may be eligible for both monetary compensation and free services from one or more of many healthcare grants being offered in Colorado.

CORHIO is participating in several of the healthcare grant programs and partnering with medical practices to help them participate and receive incentives. Here are details on three of these grants -- Evidence Now Southwest, Transforming Clinical Practices Initiative, and State Innovation Model. The commitment required from practices varies, but at a minimum, the grants ask participating practices to compile basic data for process and outcomes measures tracking and/or to participate in care coordination improvement programs.

Financial Incentives

Some of the grants offer cash incentives ranging from $500 to $5,000 (see details below). Additionally, CORHIO is able to offer free quality improvement and EHR assistance as well as some health information exchange services.

Individual Grant Details

Evidence Now Southwest – focused on building a quality improvement program using cardiology measures

- Eligibility: Primary care, internal medicine, geriatrics - independent, non-hospital owned (10 or less providers per site)
- Practice Commitment: nine months; attendance at two learning sessions, submit cardiology clinical quality measures (CQMs)
- Practice Incentive: $500 per site, includes Meaningful Use and practice facilitation help from CORHIO, select practices will receive extra assistance with patient engagement facilitation (determined by county)

Transforming Clinical Practices Initiative (TCPI) – focused on making progress through phases of transformation for primary care and specialty care, including care coordination, medical neighborhood, and value-based compensation

- Eligibility: Primary care, internal medicine, geriatrics, pediatrics, specialists - independent, non-hospital owned
- Practice Commitment: Attend regional learning sessions, work with practice facilitator, submit measures
- Practice Incentive: TBD

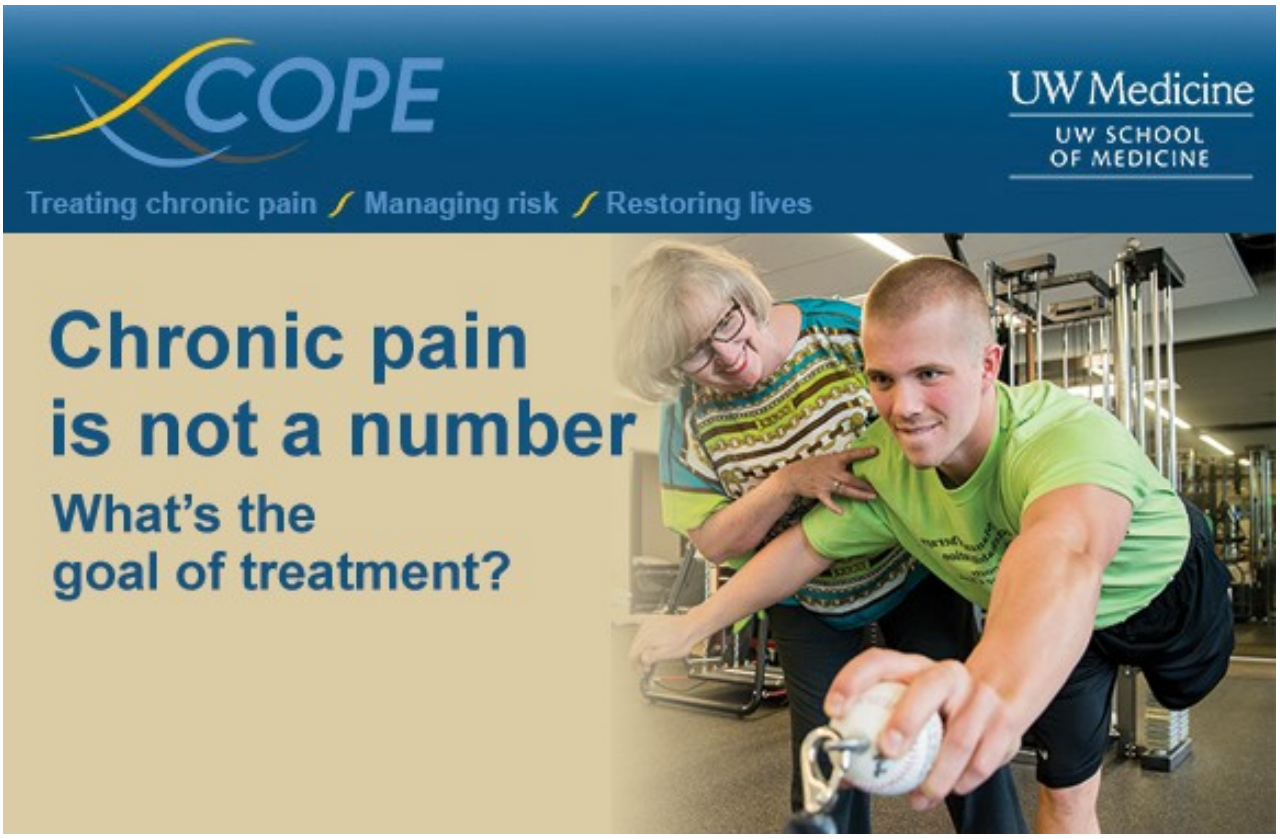
State Innovation Model (SIM) – focused on comprehensive primary care with emphasis on behavioral health integration, medical home, and reformed payment

- Eligibility: Primary care, internal medicine, geriatrics, pediatrics - independent, non-hospital owned (10 or less providers per site)
- Practice Commitment: Three years, attendance at two learning sessions, submit CQMs
- Practice Incentive: Up to $5,000 plus payment incentives from the payers
- Please note: the application deadline for the first round of SIM has passed, but there will be additional opportunities announced

To Learn More

Call CORHIO at 720-285-3245 or email info@corhio.org. We will ask you a few questions to find out which grants you may qualify for and can explain the amount of stipend and services you are eligible to receive. Participation in the grant programs is limited, and once the spots are filled, the program cannot accept any more practices.

Download the catalog of Colorado's Primary Care Advancement opportunities from Colorado Health Extension System.



A focus on reducing pain scores rather than improving function and quality of life has impeded effective treatment of chronic pain, according to a recent commentary published in the *New England Journal of Medicine* by Jane Ballantyne, MD, FRCA, and Mark Sullivan, MD, PhD, both of the University of Washington School of Medicine in Seattle.

Currently, most treatment for chronic pain is focused on decreasing scores on the basic pain scale (patients' self-reported rating of their pain on a scale of 0-10). This has contributed to overprescribing of opioids, with increased risks for patients, write Ballantyne and Sullivan. They argue that treatment for chronic pain should instead focus on careful analysis of the complex causes and consequences of pain for each patient. Chronic pain should then be addressed through multimodal therapy that integrates behavioral, physical, and medical treatments.

To learn how to model conversations with patients facing chronic pain, and for other guidance on how to safely address opioid prescribing, get trained today. COPE for Chronic Pain CME stresses constructive dialogue and shared decision-making between providers and patients.

Learn More: Take COPE for Chronic Pain's no-cost CME. Read a summary of the NEJM commentary.

About COPE: The University of Washington's COPE for Chronic Pain CME Program offers evidence-based clinical knowledge and training on how best to treat patients experiencing chronic pain. COPE CME helps clinicians assess patients and monitor their progress, mitigate risk, and focus on restoring function and quality of life. It provides guidance on when and how to start, stop, or modify opioid therapies. COPE's online course includes case-based video vignettes that model interactions between providers and patients, helping to improve communications that promote trust. Live and web-based CME is available. For more information, contact the COPE for Chronic Pain CME Program, University of Washington: www.COPEREMS.org, cope@uw.edu.