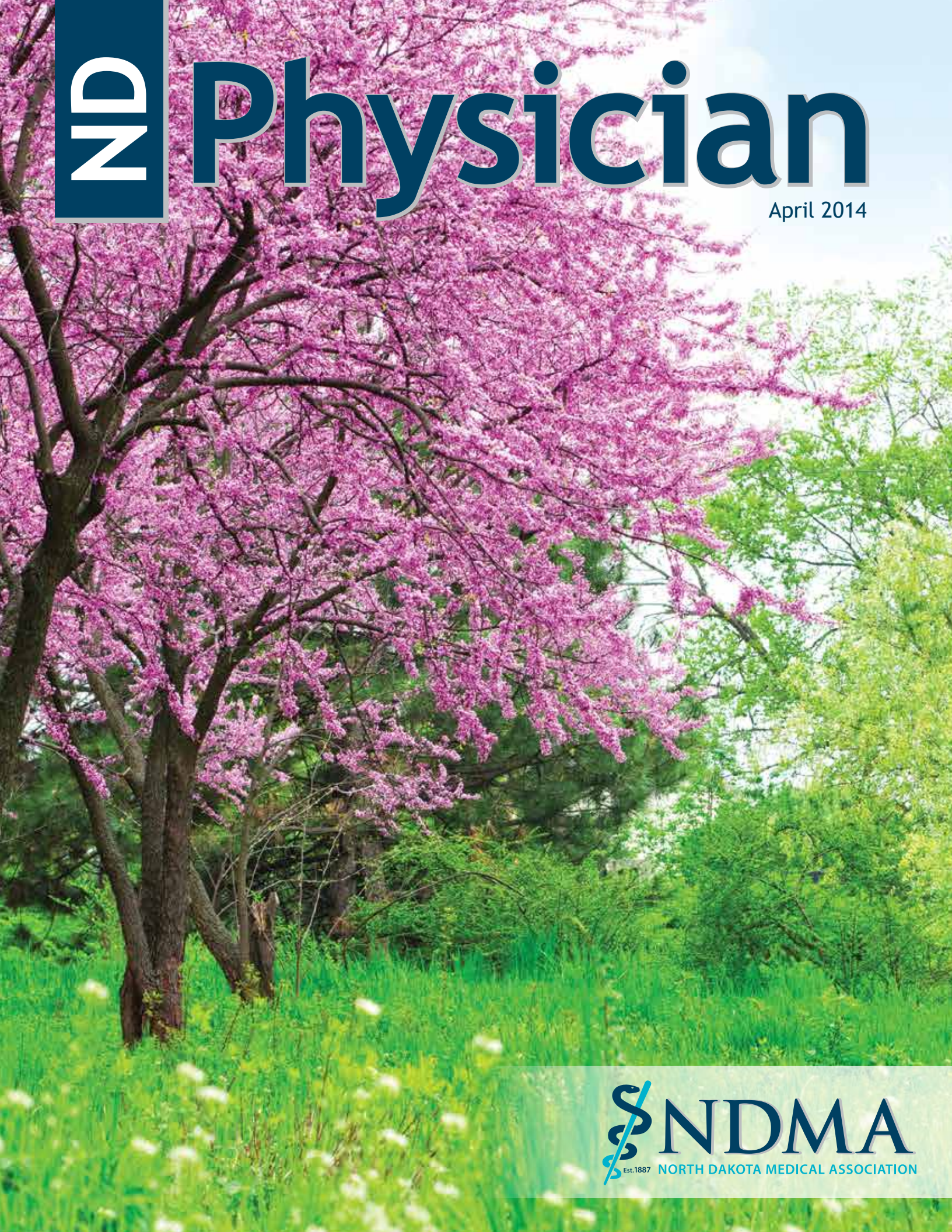

ND Physician

April 2014

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

ND Physician

North Dakota Medical Association

The mission of the North Dakota Medical Association is to promote the health and well-being of the citizens of North Dakota and to provide leadership to the medical community.

Submissions
ND Physician welcomes submission of guest columns, articles, photography, and art. NDMA reserves the right to edit or reject submissions. All contributions will be returned upon request.

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Physician Advocate

Maintaining NDMA's Presence While Preserving Resources

I am going to take the opportunity in this edition of the Physician Advocate to discuss a few structural things about NDMA, as you may notice a few changes, but first, a moment of self-reflection and disclosure.

I am not a policy wonk. I have always admired physicians who can recall arcane statistics and see nuanced connections between isolated facts and actions as that is something I struggle with. I can memorize statistics and facts but never seem to have them on the tip of my tongue when I need them. For that reason (among others), I could not have become an academic physician. I have practiced medicine in North Dakota for 31 years and for a simple country doc, working in terms of 'better than', 'worse than', and 'oh my, that is not good' has served me well.

We need to maintain the organization and functions of NDMA while we establish and maintain principles that will guide us in our purpose of advocating for our physicians and for the best health care possible for our patients.

My interest in NDMA is in overall structure and broad policy concepts. We need to maintain the organization and functions of NDMA while we establish and maintain principles that will guide us in our purpose of advocating for our physicians and for the best health care possible for our patients. I can do those things and will trust that the policy wonks in our organization will point out the details.

One of the organizational responsibilities is to establish a budget under which we will function. Quite simply, just like any other budgeting process, we need to make responsible choices for the future with the information we have presently.

We have a good relationship with the state's large provider groups, and must, since they employ about 85% of North Dakota's physicians. This year, one of the large groups in our state changed from a super payer (a provider that automatically paid for all of their physicians to be NDMA members on a yearly basis) to an opt-in system. They still budget for and pay NDMA memberships for their physicians but each physician must indicate in a positive manner their intent to continue membership.

This is in no way a bad thing. The system involved continues very positive support of NDMA and we do want physicians to see value in and continue membership in NDMA. It has been a productive and valuable exercise for us; to justify membership to the physicians of North Dakota, and ourselves, as we establish a program of recruitment.

Despite that standing support of NDMA by the large group, we have a decrease in membership, which results in a decreased budget. This is occurring in a state society that is already one of the smallest in the nation in membership, staff, and budget, so a hit to our membership to any extent results in a large impact.

We went through a contemplative and conscientious budget process. My first priority was to preserve our staff. We accomplish extraordinary things with a very talented but small staff. A loss of staff would markedly impair our ability to participate in North Dakota's health policy milieu.

Steven P. Strinden, MD

Knowing that our office team of four would remain in place, and the operating budget is already as minimal as possible, our budget reduction was made up principally in two areas:

Travel

We live and work in a national health care environment and it is imperative that we are cognizant of national policy and activities in other states, so we must continue to interface. As always, we will be very critical of what forums we will budget to attend, but even more so.

Printing

You are reading this online. We eliminated printed materials almost entirely from our budget. In this new millennium, it is becoming the norm to use electronic medium as a principle means of communication. We will see what our members think of this change.

We felt that spending decreases in these areas would allow us to maintain the high-functioning capacity and presence of NDMA all while preserving our resources.

The bottom line for us remains the same: if people are talking health care policy in North Dakota, NDMA will be in the conversation.

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NDMA in Action

NORTH DAKOTA MEDICAL ASSOCIATION

Preparations for the 2015 Legislative Session are Underway

It's difficult to believe that we are already getting ready for the 2015 legislative session! NDMA's Commission on Legislation had its first meeting in February and issues are beginning to take shape for NDMA's 2015 legislative agenda.

North Dakota has the luxury of watching other states' legislative sessions unfold, observing which issues have traction with state policy makers. The AMA conducted a survey of all the states to find out the top issues for medical societies in 2014. The responses were: state implementation of the Affordable Care Act (ACA); Medicaid expansion/reform; and ensuring physician-led team-based care. Other issues that are expected to be addressed by states in 2014 include e-prescribing, IT-related issues (e.g. electronic medical records, health information technology, telemedicine, to name a few), biosimilars, antitrust reform, efforts to grow the business of medicine, and protecting the patient-physician relationship.

In Ohio, the Medical Society has been dealing with a number of bills to address opiate and prescription drug abuse. One bill was particularly onerous – it required a broad mandate for all prescribers of a controlled substance (schedule II or contains an opioid) to check the state's Prescription Drug Monitoring Program (PDMP) with no exceptions. The Medical Society was opposed to the bill and worked closely with the legislature to modify it. The medical society's suggestions and input to the legislature were well-received, and the result was a bill that was much improved from the introduced version.

The positive changes included a section providing that if treatment continues for more than 90 days, the prescriber must make a "periodic check" of the patient's prescription drug monitoring report. The second aspect of the changes required a mandatory check of the PDMP only when prescribing opiate analgesics and benzodiazapenes and no check is necessary if a report on the patient is unavailable; the prescriber is treating a hospice or terminally ill patient; the prescriber is treating cancer; if the prescription is in an amount not beyond seven days; and finally, no check is necessary if the prescriber is treating acute pain in a post-operative setting.

By limiting the mandatory check just to opiates and benzodiazapenes, the Ohio proposal focuses on the two drugs most responsible for overdose deaths. And by implementing the exceptions, the law limits the situations where a check of the PDMP is mandatory to situations where a check is likely to occur anyway. The modified bill is under consideration by the Ohio legislature.

Courtney M. Koebele, JD

In North Dakota, it is highly probable that the legislative session will bring further regulation in this area for North Dakota physicians. This is of particular interest to NDMA, because this issue was contentious during the 2011 session and it is currently at the top of North Dakota legislators' concerns. Because of this, NDMA is involved in a North Dakota taskforce called Reducing Pharmaceutical Narcotics in our Communities through Education and Awareness. The task force is made of up of regulators, prescribers, dispensers, insurers, and law enforcement. One proposal that's gaining momentum in this taskforce is a proposal for legislation directing regulatory boards to enact guidelines through administrative rule regarding the proper prescribing of opioids and proper utilization of the PDMP.

The AMA conducted a survey of all the states to find out the top issues for medical societies in 2014. The responses were: state implementation of the Affordable Care Act (ACA); Medicaid expansion/reform; and ensuring physician-led team-based care.

NDMA is involved in a North Dakota taskforce called Reducing Pharmaceutical Narcotics in our Communities through Education and Awareness. The task force is made of up of regulators, prescribers, dispensers, insurers, and law enforcement.

The North Dakota Board of Medical Examiners (NDBOMEX) has developed guidelines that are not in administrative code; however, the Board will consider the use or non-use of the PDMP in accordance with its guidelines as evidence of whether a practitioner has met the requirements of the North Dakota Medical Practice Act, 43-17-31, N.D.C.C.

These NDBOMEX guidelines address the use of the PDMP by physicians prescribing those drugs reported by the program, which include any controlled substance, tramadol, and carisoprodol.

If a physician prescribing any drug reported by the PDMP has reason to believe that a patient may be abusing or diverting prescribed medications, the physician shall access the PDMP and document the assessment of the monitoring results to help determine the proper treatment of the patient.

A. When the physician has knowledge that the patient exhibits any of the following signs of potential abuse or diversion, the physician shall request a report from the PDMP:

1. Selling prescription drugs;
2. Forging or altering a prescription;
3. Stealing or borrowing reported drugs;
4. Taking more than the prescribed dosage of any reported drug;
5. Having a drug screen that is inconsistent with the prescribed drugs by indicating that the patient is not taking the prescribed drugs, is taking additional or illicit drugs, or refusing to take a drug screen;
6. Being arrested, convicted or diverted by the criminal justice system for a drug related offense;
7. Violating any prescribing agreement with the physician;
8. Receiving reported drugs from prescribers not disclosed to the treating physician;
9. Having a family member, law enforcement officer, or health care professional express concern about the patient's use of reported drugs.

B. When the patient exhibits any of the following signs of potential abuse or diversion, the physician should consider requesting a PDMP report:

1. Frequently requests early refills of a reported drug for any reason;
2. Appears impaired or excessively sedated to the physician in any patient encounter;
3. Requests reported drugs by street name, color, or markings;
4. Has a history of drug abuse or dependency.

C. When a physician expects to prescribe reported drugs to a patient for a chronic condition or for a protracted basis, the physician shall request a PDMP report:

1. Upon determining that such prescribing will be on a protracted basis;
2. At least annually thereafter.

D. A physician shall document the receipt and assessment of PDMP reports made under these guidelines and include them in the patient's medical record.

These guidelines can be accessed at https://www.ndbomex.org/

NDMA will continue to participate in the task force and committee hearings about this issue and work toward combating diversion and drug abuse while at the same time preserving access to medically necessary treatment for pain. NDMA strongly supports positive incentives to promote physician education as well as strategies that integrate education into a physician's practice. NDMA will continue to promote useful tools, such as the PDMP, that physicians can use at the point-of-care to support medical decision-making.

SUPPORT NDMA PAC!

NDMA

The North Dakota Medical Association Political Action Committee (NDMA PAC) advocates on your behalf regarding crucial issues you encounter on a daily basis.

Politics have become more deeply embedded in the daily practice of medicine, which requires physicians to become more involved in the political process. Without active and engaged involvement, the voice of the physician community will not be heard or understood. The NDMA PAC plays a crucial role in these efforts through intentional action and advocacy. However, without your support, we will not have the necessary financial resources available to support candidates who are proven friends of medicine.

Your time is valuable and joining NDMA PAC is the quickest, easiest, and most effective way to make your voice heard in the political process. Please consider supporting your NDMA PAC with a financial gift today!

Building the Health-Care Workforce

News from the Dean of the UND SMHS

After an intense nine-month planning period, we are shifting from the conceptual to the construction phase for the new School of Medicine and Health Sciences building. Support pilings have been hammered into the ground to support the new building, and groundbreaking will take place early this summer with an expected completion date of July 2016. The building will be a four-story, 320,000-square-foot facility with a north–south oriented "Main Street" around which will be clustered various classrooms, small-group rooms, lecture halls, simulation and gross anatomy labs, and other associated educational support space. To the east will be a wing for faculty and administrative offices, and the west wing will house much of our research enterprise. Our colleagues from JLG Architects and associated firms currently are preparing construction blueprints that will be used to solicit bids for the construction phase of the project. One can feel the excitement build as everyone realizes that what once was a dream is fast becoming a reality! One of the particularly noteworthy features of the layout are the two office suits adjacent to the front entry to the building that will service our two most important constituencies—students and the people of North Dakota who are footing the bill for the new facility. The Office of Student Affairs and Admissions will be front and center to welcome prospective and to assist current students, just as UND has done in the new UND Foundation Gorecki Alumni Center. The Office of Alumni and Community Relations will similarly welcome and assist the public, voluntary community faculty members, and alumni visiting the building. We very much hope that the community will utilize their building. To facilitate this, we've designed a capacious learning hall (auditorium) by the front entrance and adjacent to the two office suites. It is, after all, the people's building! You can see renderings and floor plans of the building at this link: *http://www.med.und.edu/construction/renderings.cfm*.

But let's keep the excitement about the new building in perspective—if that is possible!—and recall that the primary reason we need a new building is to accommodate the class size expansion that will be required to provide the health-care workforce our citizens need and deserve? Pretty well, I think. We've already expanded medical student class size by eight students this past year, and the health sciences class size by 15. And we've added new residency slots in rural family medicine, rural surgery, and hospitalist medicine.

We very much hope that the community will utilize their building. To facilitate this, we've designed a capacious learning hall (auditorium) by the front entrance and adjacent to the two office suites. It is, after all, the people's building!

Joshua Wynne, MD, MBA, MPH

Thanks to enhanced emphasis during our admission process on the School's rural-care-delivery mission, we've increased the percentage of the matriculating class that hails from rural North Dakota. This is vitally important.

Eight more medical students (a total of 16 additional students) and 15 more health sciences students (a total of 30 additional students) will join us this fall. Thanks to enhanced emphasis during our admission process on the School's rural-care-delivery mission, we've increased the percentage of the matriculating class that hails from rural North Dakota. This is vitally important, since being raised in a rural area is one of the best predictors of subsequently practicing in a rural area. As a consequence of both the recruitment of rural students and the expansion of class size, we already have increased the number of students in the first-year medical school class that hail from rural North Dakota by four students when comparing the Class of 2017 to that of 2011. This occurred at the same time that there

Between the new building and new and expanded programs, the School is doing its best to help address North Dakota's health-care provider needs now and in the future.

actually has been more population growth in urban areas than rural areas, oil boom notwithstanding. By the way, North Dakotans overall have composed about 80 or more percent of our first-year medical school class over recent years; about 10 percent hail from Minnesota, but usually with North Dakota connections, and the remainder are from WICHE (Western Interstate Commission for Higher Education) states that don't have their own medical schools. We continue to offer seven medical school slots each year as part of the federally funded Indians into Medicine (INMED) program.

Importantly, several additional residency slots recently were approved by the School of Medicine and Health Sciences Advisory Council—two additional rural family medicine slots, one in Hettinger and one in Williston; an additional rural surgery slot; and an additional hospitalist slot centered in Bismarck. We are pleased to note that both the Hettinger and Williston rural training tracks in family medicine recently have been approved and endorsed by the Accreditation Council for Graduate Medical Education, thus validating the solid educational experience available in these two western locations (the first year of the three-year, rural-track family medicine residency is spent on the home campus of either the Bismarck [Hettinger] or Minot [Williston] Centers of Family Medicine). A second round of residency slot competition will take place later this spring, with a focus on developing residency programs that address behavioral and mental health issues, and programs that suggest novel and innovative approaches to resident education. Applications for the remaining residency slots are due July 1, and the awards should be announced shortly thereafter. So between the new building and new and expanded programs, the School is doing its best to help address North Dakota's health-care provider needs now and in the future.

North Dakota's Underage Drinking: We All Play a Role

Pam Sagness, LAC, Prevention Administrator with the Division of Mental Health and Substance Abuse Services

Alcohol continues to be the most abused substance among North Dakota's youth. According to the 2013 North Dakota Youth Risk Behavior Survey, 21.9% of high school students reported past month binge drinking. Although these rates are decreasing (32.5% in 2007) it is important to make sure prevention efforts continue.

Almost 1 in 6 (15.2%) of North Dakota's high school students report having their first drink of alcohol before 13 years of age (YRBS, 2013). Youth who begin drinking before age 15 are four times more likely to become alcohol-dependent than those who wait until they are 21 (Center for Adolescent Health).

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Underage drinking impacts us all. One in ten (9.6%) alcohol-related fatal crashes involved an impaired driver under the age of 21 (DOT, 2012). Also, 17% of juvenile arrests were alcohol-related (Crime in ND, 2011).

Healthcare providers play an important role in preventing underage drinking. There is considerable evidence for the effectiveness of brief interventions for harmful drinking when delivered by a physician or other qualified health professional. Every day there are opportunities to take advantage of teachable moments with patients.

1. Ask youth about their alcohol use
2. Talk with parents about how they are having the conversation with their children and encourage them to:
   - Continue conversations with their children about alcohol and other high-risk behaviors
   - Share family values
   - Be a positive role-model
   - Be active and engage in their children's lives.

Resources are available at **Parents LEAD** to support you in this work. Parents LEAD (Listen, Educate, Ask, Discuss) is a North Dakota-developed underage drinking prevention effort targeting parents through a statewide, web-based communication. The program is designed to help parents initiate and/or continue conversations with their children about underage drinking and other difficult subjects at any age. A key component of the program is a professional portal offering tips, tools, and resources for professionals working with families.

We can all play a role in preventing underage drinking and related consequences. Continue having conversations with patients and encourage them to have conversations at home. For more information, visit Parents Lead at: *www.parentslead.org* or for professional tools visit: *www.parentslead.org/professional.*

Healthcare providers play an important role in preventing underage drinking. There is considerable evidence for the effectiveness of brief interventions for harmful drinking when delivered by a physician or other qualified health professional. Every day there are opportunities to take advantage of teachable moments with patients.

1 According to the National Institute on Alcohol Abuse and Alcoholism, binge drinking is defined as, "a pattern of drinking which brings a person's blood alcohol concentration (BAC) to .08 grams percent or above."

2 Bien, T., Miller, W. R., & Tonigan, J. S. (1993). Brief interventions for alcohol problems: A review. Addiction, 88, 315-336.; Kahan, M., Wilson, L., & Becker, L. (1995). Effectiveness of physician-based interventions with problem drinkers: A review. Canadian Medical Association Journal, 152, 851-859.; Wilk, A.I., Jensen, N.M., and Havighurst, T.C. (1997). Meta-analysis of randomized control trails addressing brief interventions in heavy alcohol drinkers. Journal of General Medicine, 12 (5), 274-283.; Whitlock, E.P.; Polen, M.R.; Green, C.A.; et al. Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: A summary of the evidence for the U.S. Preventive Services Task Force. Annals of Internal Medicine 140:557-568, 2004.

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Warren Albrecht, DO
Andrew Bakken, MD
Peter Biegler, MD
Jon Machayya, MD
Eric Promersberger, MD
Todd Reil, MD
David Stover, MD
Corey Teigen, MD

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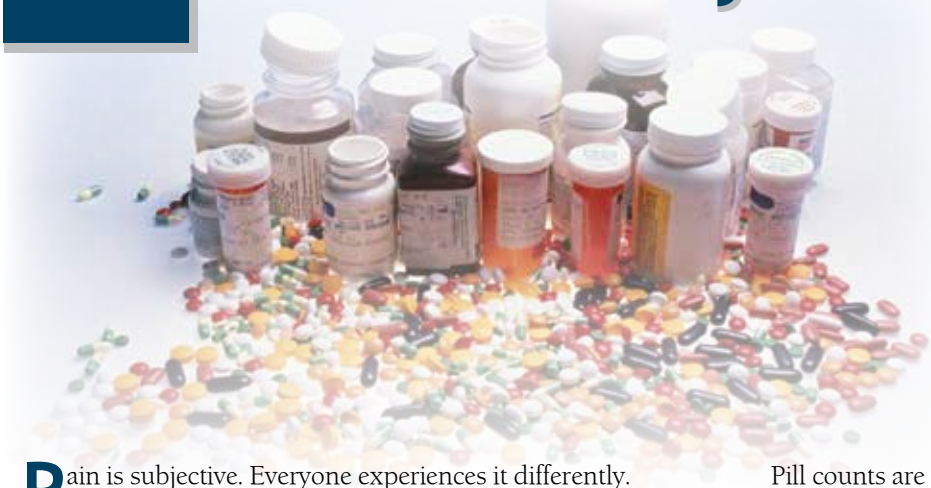
Managing Narcotic Prescriptions for Pain: A Physiatrist's Perspective



Shelley Killen, MD, Physical Medicine,
Physiatrist, St. Alexius Medical Center

Pain is subjective. Everyone experiences it differently. Therefore, the first step is to assess a patient's pain and determine if narcotics are the right treatment choice and if they will play a large or small part in an overall treatment plan. This plan also may include non-steroidal anti-inflammatory drugs, antidepressants, and/or exercise programs and modalities, such as hot or cold treatments. At an initial visit, we use a screening tool that looks at a person's risk for abusing medications. We also establish any prior history of substance abuse, illicit drug use, and/or sexual abuse or domestic violence. In those cases additional counseling also may be warranted. Current tobacco and alcohol use is also recorded.

Once it is determined that narcotics may be an appropriate treatment plan, we review with a patient the narcotic contract that clearly spells out the responsibilities of both the patient and the physician.

Once it is determined that narcotics may be an appropriate treatment plan, we review with a patient the narcotic contract that clearly spells out the responsibilities of both the patient and the physician. We expect only one pharmacy to be used by the patient to fill those specific drugs, and requests for early refills may not be honored. We also make it clear to the patient that we are available for refills Mondays through Fridays, specifying the hours. We do not allow for weekend refills. To avoid the argument about this policy, we try to follow a 28 day fill rule so the patient is due the same day of the week every four weeks. The exception to this rule is fentanyl patches, which are filled every 30 days.

We perform a urine drug test at a patient's visit and then randomly thereafter or if there is suspicious behavior. We use a lab with a no threshold standard, so if a drug is present in the urine, it is easily detected. With urine drug screens we are looking to make sure the patients are taking the drugs that have been prescribed for them and no others or illicit ones. Staff is usually available to assist with any interpretation.

Pill counts are a routine part of follow-up appointments. For out of town patients, we have them present to their pharmacy for a pill count. Failure to do so may result in their termination from the program. Our contract also states there will be no sharing of medications and that medications only will be taken as prescribed. As a measure of the effectiveness of the treatment program that includes narcotics, we monitor the patient's functional abilities in day-to-day activities. Patients need to remain functional for a treatment plan to be successful.

I always make it a point to discuss medication storage with a patient. I recommend that medications be locked up in either a safe or a small, locked box. I discourage patients when they tell me they keep them on the top shelf, out of the reach of children. Children can climb, and if someone wants your medications, they will search high and low until they find them.

We always check the North Dakota Prescription Monitoring Program at the initial contract and continue to monitor it to ensure that our clinic is the only provider of the prescribed narcotic. This has been an invaluable tool in patient care.

When a narcotic contract is violated or a random urine drug screen returns with unexpected results, I confront the patient with the situation and take appropriate action. This could include: referral for substance abuse treatment; tapering of narcotic medications and continuation of care; or termination of care with referral to another provider (with a taper if a provider cannot be found).

We always check the North Dakota Prescription Monitoring Program at the initial contract and continue to monitor it to ensure that our clinic is the only provider of the prescribed narcotic. This has been an invaluable tool in patient care.

Treating pain truly can be a challenge, but if narcotics are an option for a patient, seeing their quality of life improve makes it worthwhile.

The Pharmacist's Role to Reduce Opioid Abuse

Nicole Boustead, Pharm.D., R.Ph.
St. Alexius Community Pharmacy
Staff Pharmacist

Prescription opioid abuse and diversion has become an epidemic that should concern all prescribers of opioid drugs. With the number of chronic pain suffers increasing at a staggering rate, proportionately we can expect that a certain percentage of these patients will either abuse or divert prescription medications even when using these medications as prescribed.

The Prescription Drug Monitoring Program (PDMP) has been a step in the right direction, but the question remains what to do with the information. How is the number of prescribers, medications, and pharmacies on the report supposed to be interpreted and which provider of the healthcare team queries the system? What happens when the pharmacist query at 7:00 PM on a Friday evening is questionable and the prescriber is not available? If the prescription is denied at one pharmacy, it is likely the patient will eventually find a pharmacy to fill the prescription. If PDMP laws are implemented on the pharmacy end, it could be possible that a patient in true pain with a true legitimate purpose could get denied the medication he or she needs when the prescriber is not available. If the prescriber is proactive in using the PDMP, the decision of what to prescribe becomes evident if abuse or diversion is suspected. At that point, if an opioid is chosen the prescriber already has a history and a better plan to monitor for signs of abuse.

Prescribers of large quantities of opioid medications should require patients to comply with regular and random pill counts and drug screens to ensure diversion issues are addressed and ensure the patient is using within the directions of the prescription. Collaboration with the patient's pharmacy can also be useful in providing pain and medication consultation. Pharmacy staff generally has a minimum of three interactions per month for chronic opioid patients. First, the patient's refill request called into the pharmacy. The second interaction is to find out when the prescription will be filled, and the third and final interaction is when the medication is picked up and consulted by the Pharmacist.

So with the three minimum interactions per month with these patients, can pharmacy staff members distinguish between patients that have legitimate pain, abuse concerns, or diversion characteristics? If it were that easy, diversion and abuse would not be epidemic. When a patient receives a prescription for hydrocodone or oxycodone for a seven-day supply following a surgery, it is not likely addiction will result and it would be considered a lesser chance than someone coming in for a scheduled monthly opioid with a large quantity as needed immediate release opioid, but impossible to predict. Always encourage patients to accept a pharmacist consultation when picking up opioid medications even though the medical consult was done. While the pharmacist consultation might overlap the medical consult, it may provide additional specific information including: emphasis on avoiding alcohol; driving warnings; combining with other medications; not sharing medications; secure storage; disposal; written information; and/or adverse effects. Pharmacists can answer questions that might arise from the consultation that might not have come to the patient's mind in the doctor's office. Together, with the prescriber and the information available on the PDMP, we can provide safe, responsible, and appropriate care to our patients.

Your care team is now just a tap away.

DocbookMD is a free benefit for NDMA members.

DocbookMD has now made it easier than ever to engage and communicate with your non-physician colleagues in a new feature to our app called Care Team. With Care Team, physicians can invite members of the patient care team to join them on DocbookMD to communicate in a secure, fast and efficient way through their mobile device. Now, all of those caring directly for patients can share messages and images like X-rays, EKGs and images of wounds or rashes wherever and whenever they need to. Simply download the app from either the App Store or Google Play and start building your Care Team.

Available on the App Store

Get it on Google play

For more questions, please visit docbookmd.com or you can contact us at 888-930-2048 or info@docbookmd.com.
The Care Team feature is only available with the latest app version of 5.0.

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NDMA NORTH DAKOTA MEDICAL ASSOCIATION

NDHIN: Secured and Simplified Communication

The Health Information Technology Advisory Committee, which is made up of healthcare stakeholders, is implementing a statewide, secure health information network known as the North Dakota Health Information Network (NDHIN). The NDHIN is a simplified and robust infrastructure allowing providers to securely exchange health information. Providers using the NDHIN will be able to share information through a secure simplified process known as NDHIN Direct and through the Clinical Portal which is a more robust query exchange of health information.

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NDHIN Direct allows a provider to send information to another provider through a secure electronic system. It allows providers to exchange unstructured documents or structured files with other providers through a secure email service; essentially, it is pushing protected health information to another provider securely.

The Clinical Portal is a more robust exchange of health information, also known as query technology, which includes the capability to find information on a patient that is needed to provide good quality healthcare. Information that may be obtained includes, but is not limited to: medications, allergies, lab results, and advance directives. Essentially, the query technology is another tool that a provider can use to push information to another provider, or if necessary, pull information from other providers as they are providing medical services to a patient.

The NDHIN is now LIVE (see Governor Dalrymple's press release here: *http://governor.nd.gov/media-center/news/dalrymple-officials-launch-north-dakota-health-information-network*) and in the process of onboarding many facilities, which includes the six large hospitals. 147 healthcare organizations have signed participation agreements to be a part of the network, thus far, and approximately 680 users have been enrolled in NDHIN Direct. In efforts to educate providers and healthcare staff, we offer webinars and other informational documents to provide information and answer questions about the NDHIN and how to communicate this information to your patients. The information is available on our website

Sheldon Wolf

at *www.ndhin.org/providers/training*. Another great resource is a short video about the NDHIN that can be found at *www.ndhin.org/video/provider-education-video*.

Additionally, the NDHIN will include access to the prescription drug monitoring program (PDMP). To minimize the number of places that a provider needs to go to obtain information, the NDHIN is in the process of building the PDMP access into the clinical portal. This will allow providers to access the information from one location. This functionality should be available in April 2014. When this function is available, additional training will be provided on how to access and utilize the information that will be available.

To find out more information about the NDHIN, its PDMP compatibility, or any other concerns, visit *www.ndhin.org*.

NDHIN
North Dakota Health Information Network
Quality Healthcare for All North Dakotans, Anywhere, Anytime.

147 healthcare organizations have signed participation agreements to be a part of the network, thus far, and approximately 680 users have been enrolled in NDHIN Direct.

Tobacco Tax: Raise it for Health

At a time when North Dakota faces so many incredible opportunities and challenges, it's important that we don't lose focus – or allow our policymakers to lose focus – on the work you do each and every day to improve the health and wellbeing of our fellow North Dakotans. We appreciate the chance to come together with the North Dakota Medical Association to advocate for proven policies that benefit public health, and engaging in a serious conversation about our state's current tobacco taxes is a perfect place to continue to our work together.

Deb Knuth
ACS-CAN Government Relations Director
Chair of Raise it for Health North Dakota

Did you know North Dakota has one of the lowest tobacco taxes in the entire nation, even lower than most tobacco-producing states? Did you know we are one of only three states that hasn't increased our tobacco tax in the last 10 years? In fact, it's been over 20.

Years of studies show the correlation between high tobacco prices and low use rates, and there's only one way to increase the price of tobacco, and that's to raise the tax.

The average state cigarette tax in the United States is $1.53 per pack, and North Dakota's current cigarette tax ranks 47th lowest at $0.44 per pack. 21.2% of adults and 19.4% of youth in North Dakota continue to smoke (compared to, respectively, 19.0% and 18.1% nationally), and these addictions continue to contribute to serious public health issues like chronic disease and a number of cancers. Years of studies show the correlation between high tobacco prices and low use rates, and there's only one way to increase the price of tobacco, and that's to raise the tax.

The American Cancer Society Cancer Action Network (ACS CAN), American Lung Association (ALA), and Tobacco Free North Dakota (TFND) are proud to work together in spearheading a campaign and leading a broad-based coalition of organizations and individuals, under the name of "Raise it for Health North Dakota," in support of raising North Dakota's current tobacco taxes through legislative action in 2015.

Our support for raising the tobacco tax is strictly about the health benefits tied to high tobacco prices, and no one knows the power of prevention (and cessation) like those in the medical field. We acknowledge the challenges that lie ahead given our state's political climate and budget surplus, but we want to rise together to meet the next opportunity available to educate on, advocate for, and enact this policy which brings with it incredible benefits to public health.

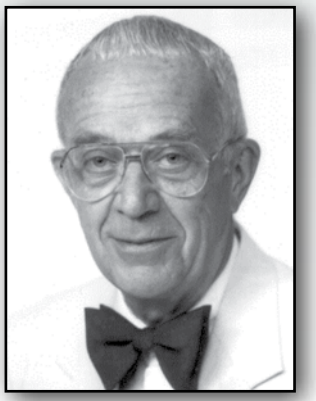
It is our hope that the members of the North Dakota Medical Association recognize the need to address this issue and officially join our coalition. Your voice and advice, coupled with the expertise you bring and the care you provide to your patients all over North Dakota, will help strengthen our message. Raise it for Health North Dakota would welcome any opportunities to further discuss the benefits of increasing the tobacco tax with members and partners of NDMA and hope you'll join us very soon.

For more information, go to:
www.facebook.com/RaiseItForHealthND.

IN MEMORIUM

Honoring members of the North Dakota Medical Association who passed away in 2013

Ben Clayburgh, MD



Joseph W. Cleary, MD

Martha E. Glower, MD

Dale C. Kana, MD

Stanley W. Keck, MD

Antonio R. Rillo, MD

John C. Smith II, MD

Thomas N. Spagnolia, MD

Glenn L. Wiltse, MD

"Whenever the art of medicine is loved, there is also a love of humanity."
-Hippocrates

Answering Patients' ACA Questions Made Simple

By the American Medical Association

More than 80 percent of physicians say they don't have enough information about the Affordable Care Act (ACA) to answer patients' questions or understand its impact on their practices, according to a ***recent survey***. Fortunately, the AMA offers resources with answers that can help ease this transition for your patients and practice.

Download an ACA ***fact sheet*** for helpful information about the ACA rollout, including information about the new insurance exchanges, Medicare benefits and the individual mandate. An accompanying ***FAQ document*** provides answers to common questions from patients.

The Department of Health and Human Services also offers a ***patient brochure*** about the health insurance exchanges, ***guidance*** on how the Healthcare.gov website works, and a patient ***pocket card*** listing relevant websites and phone numbers.

A new ***checklist***, developed by the AMA and the Medical Group Management Association, identifies six actions that can ease some of the administrative challenges physicians and their patients may face during this implementation phase. The checklist includes recommendations on training staff, discussing cost information with patients and understanding your state's essential health benefits.

The AMA continues to work with the federal government to troubleshoot issues surrounding the ACA as they arise and develop additional guidance to help physicians. More resources and information will be added to the AMA's ***Web page*** on the ACA as they become available.

Patient Safety Advocacy
Truth in Medical Advertising Survey*

ASDSA
American Society for Dermatologic Surgery ASSOCIATION

99% want to know **what type of practitioner** is **performing** their cosmetic medical procedure

73% believe level of training is the **most important** factor when selecting their practitioner

Transparency in medical advertising allows patients to make informed decisions about where to receive their medical care.

95% want to know the **BOARD CERTIFICATION** of their physician

Only 33% of respondents **understand** medical title abbreviations (DNP, MA, RN, PA, etc.)

80% want name badges

86% want to see the **full title** spelled out on name badges

89% want to see **level of licensure** in print ads

***Source:** Smith, A.; Brod, B. Public Perceptions of Varied Providers of Cosmetic Medical Procedures in the United States. 1765 patients surveyed

asdsa.asds.net

Make-A-Wish North Dakota: Granting Wishes Since 1985

A wish come true helps children feel stronger, more energetic, more willing and able to battle their life-threatening medical conditions. Before any Make-A-Wish® staff or volunteers get involved, it starts with you - the medical community. You are there through the appointments, treatments, and most times to refer a child to Make-A-Wish® so they can begin their magical experience. As we approach our chapter's 30th anniversary we reflect on how far we have come as an organization and how you can help us to continue to advance our mission.

Our Beginnings

In the spring of 1980, U.S. Customs Agent Tommy Austin shares with Arizona Department of Public Safety Officer Ron Cox his problem. His wife's friend Linda has a small son named Chris Greicius who is probably going to die of leukemia. The seven-year-old boy yearns to be a police officer "to catch bad guys" with Austin. With his health on the decline, officers of the Arizona Department of Public Safety worked quickly to make Chris' wish come true. They arranged a day for Chris to fulfill his wish and create lasting memories for his family. It's with those humble beginnings that Chris' wish inspired the founding of Make-A-Wish.

The story of Chris and Make-A-Wish was inspiring the nation, and in 1985, a group of individuals founded Make-A-Wish® North Dakota. The chapter's first wish was granted to 7-year-old Christopher who wished to have a VCR. Since our inception, over 680 heartfelt wishes have been granted to children across the state.

"Having a wish come true has the healing power to reset their attitudes and re-energize their spirits and dreams. This is what a wish is all about! Make-A-Wish is an important part of the community at large to help in the overall care of these children."

The mission of Make-A-Wish is to grant the wishes of children with life-threatening medical conditions to enrich the human experience with hope, strength, and joy. Our mission reflects the life-changing impact that a Make-A-Wish® experience has on children, families, referral sources, donors, sponsors, and entire communities.

A recent wish impact study performed by Make-A-Wish® America showed:

Billi Jo Zielinski, President and CEO of Make-A-Wish North Dakota

MAKE-A-WISH® North Dakota

- 74 percent of wish parents observed that the wish marked a turning point in their children's response to treatment
- 89 percent of health care professionals surveyed say they believe that the wish experience can influence wish kids' physical health
- 81 percent of parents observe an increased willingness by their wish kids to comply with treatment protocols

Dr. Sachin Jogal of Children's Hospital of Wisconsin attests to these statistics when he says, "Having a wish come true has the healing power to reset their attitudes and re-energize their spirits and dreams. This is what a wish is all about! Make-A-Wish is an important part of the community at large to help in the overall care of these children."

Our vision is to make every eligible child's wish come true. While more than 14,000 wishes were granted across the United States last year alone, this reached only half of the eligible children diagnosed with a life-threatening medical condition. This is why your role is so important.

Eligibility and Referral

A child with a life-threatening medical condition who has reached the age of 2 1/2 and is younger than 18 at the time of referral is potentially eligible for a wish. Every year, 49 families in North Dakota learn their child is diagnosed with a life-threatening medical condition.

Children who may be eligible to receive a wish can be referred by one of four sources:

- Medical professionals (typically a doctor, nurse, social worker, or child-life specialist)
- Parents/legal guardians of the potential wish kid
- Potential wish kids
- Family members with detailed knowledge of the child's current medical condition

Make-A-Wish does not cold call the families of potentially eligible kids. You play such a vital role to the success of our vision. We ask you to please exercise compassion and suggest to families that they contact us directly.

After a child is referred, Make-A-Wish will work with the treating physician to determine the child's eligibility for a wish, i.e suffering from a progressive, degenerative, or malignant condition currently placing the child's life in jeopardy.

Make-A-Wish often reviews its guidelines to ensure that it serves children with life-threatening medical conditions. We have carefully researched and reviewed guidance around our eligibility criteria for cystic fibrosis. With the support of leading pulmonologists and Make-A-Wish medical advisors across the country, we have determined that effective February 1, 2014, all patients with cystic fibrosis, except for those rare circumstances when they are free of respiratory involvement, will be eligible for a wish through Make-A-Wish.

Learn More

Join Make-A-Wish on **April 29, 2014, at 12:00 p.m. CDT** for an informational teleconference call on the referral process and medical eligibility requirements for a wish. The call is open to physicians, medical professionals and anyone who would like to learn more about Make-A-Wish. Call in to 1-866-210-1669 enter participant code: 3528036

Additional information can be found on our website *www.northdakota.wish.org*, requested via email to our Director of Program Services at kpederson@northdakota.wish.org or by calling our office at 701-280-9474. As we approach 30 years of wishes, we thank you for your continued support to ***Share the Power of a Wish®***.

CDL-CME Training Offered: Action Required Before May 2014

The North Dakota Medical Association offers convenient CDL-CME training from the comfort of your home or office. The Federal Motor Carrier Safety Administration (FMCSA) established the National Registry of Certified Medical Examiners (NRCME) which requires all health care professionals who conduct physical examinations of interstate commercial motor vehicle drivers to:

- Complete training that is accredited by a nationally recognized medical profession accrediting organization to provide continuing education units and meets the FMCSA standards
- Pass a certification exam to demonstrate that the medical examiner is qualified and competent to conduct physical examinations of drivers who wish to obtain their interstate Commercial Driver's License (CDL)
- Maintain competence by periodic training and testing

Beginning May 21, 2014, the FMCSA will accept as valid from CDL drivers only medical examiners' certificates issued by medical examiners listed on the NRCME. These requirements support FMCSA's goal to improve safety and reduce fatalities on our nation's highways.

There are training courses available from numerous organizations; however, NDMA has eliminated the need to research the various programs before you decide. NDMA's course is 100% online (conducted at your own pace) with the option to obtain AMA PRA Category 1 Credits™ (approved for 9.5 AMA PRA Category 1 Credits™). Other non-member health care professionals can also enroll in our training course; however, NDMA members receive a discounted rate. Upon completing NDMA's online training, you will be prepared and qualified to take the NRCME certification exam.

Visit the website *http://ndma.essentialeducationwebinarnetwork.com/* to register today! You can also view this information on NDMA's website or in the December 2013 issue of *ND Physician*. Please call the NDMA office at 701-223-9475 if you have any questions.

Orbiting the Patient

How patient and family centered care improves engagement and outcomes

Let's imagine that, like 70 percent of the U.S. population, you're overweight and your doctor suggests you lose 20 pounds as a way to improve several existing health conditions.

Vicky Burbach, RN, MS, CPHRM
Patient Safety Analyst

When you visit the doctor's office for your six month checkup, you're a bit apprehensive about your progress. But as you step onto the scale, the office assistant is encouraging. "Well, you have lost 3 pounds," she says, "so that's progress!" Immediately, you feel more at ease.

Then the doctor enters the examination room, and she offers similar encouragement. "What can we do to help you reach your goal?" she asks politely. "Are there obstacles I can help you overcome?"

Leaving the medical office that day, you have new resource materials the doctor has provided, and you're confident that there's a team supporting you in reaching your personal health goals.

This feeling of being an engaged member of a team – a team focused on the same goal – is the primary objective of patient and family centered care. Such "whole person" health care is a collaborative partnership among patients, families and providers. Every aspect of a patient's health – spiritual, emotional, psychological, physical, social, and cultural – is considered in the development of a personalized care plan.

Patient and Family Centered Care Supports Patients' Feelings of Confidence in Managing their own Health, which Improves Outcomes and Boosts Satisfaction Ratings

Why does it work?

Patient and family centered care supports patients' feelings of confidence in managing their own health, which improves outcomes and boosts satisfaction ratings. What's more, patients who are treated this way often adhere better to treatment plans, experience fewer complications, and use fewer overall medical services – all of which lead to reduced costs.

How does it work?

In the past, the doctor's visit described above might have been very different. Perhaps the person weighing you would have had no knowledge of your specific health goals. Or perhaps the doctor might simply have admonished, "You'd better lose that weight!"

But with a patient and family centered-care approach, the entire health care team treats patients as partners, collaborating to identify mutual goals and develop a plan of care. Communication is at the heart of this type of care.

The Institute for Patient and Family Centered Care identifies the approach's core concepts as:

- Respect and dignity. Providers listen to and honor patient and family perspectives and choices, incorporating knowledge, values, beliefs, and cultural backgrounds into planning and providing care
- Information sharing. Providers communicate and share complete, timely, accurate, and unbiased information that is meaningful and understandable to patients and families
- Participation. Providers encourage and support patients and families to participate in planning care and decision making at the level they choose
- Collaboration. Patients and families are included on a system wide basis in policy and program development, implementation and evaluation of processes, professional education, and delivery of care

Communication and care coordination

The way the health care provider and team members communicate is as important as the information itself. Mutual trust and respect are enhanced when the patient and family perceive their care team as comforting and competent. This less intimidating environment encourages the patient and family to ask questions and seek clarification whenever they need it.

But with a patient and family centered-care approach, the entire health care team treats patients as partners, collaborating to identify mutual goals and develop a plan of care. Communication is at the heart of this type of care.

Competent care, which is critical to trust and respect, is not just the responsibility of the individual provider. In this model, the entire team delivers coordinated care among providers, facilities, and community resources. This care coordination reduces fragmentation and duplication of services by filling the "gaps" between service providers, and it reinforces consistency through help episodes over time.

The role of health literacy

"Let's put a four by four on this wound."
"The tumor is benign."
"Your chest X ray is positive."
"Take this medication orally and on an empty stomach."

While phrases such as these are easily understood by health care professionals, they might cause confusion or anxiety for a patient who lacks an understanding of basic health care terms. According to the National Assessment of Adult Literacy, nearly nine out of 10 adults do not have proficient health literacy, and many lack the skills needed to manage their health and prevent disease.

Limited health literacy might make it difficult for a patient to read food labels, complete health forms, communicate symptoms, measure medication, navigate the health care system, or follow self care instructions. And the stress of an illness or a medical emergency can make everything seem more confusing, even to someone who appears to operate at a higher literacy level.

Simple communications for better outcomes

When communicating with patients, keep your language short and simple. Limit your message to no more than four main points. Explain the behavior or action you want the individual to take, rather than focusing on complex medical principles. And avoid medical abbreviations and jargon.

When discussing the situation, use open ended questions to encourage an exchange of information. For example, you might say, "Please describe your pain," rather than, "Are you in pain?"

Assume that patients will naturally have questions and encourage them with a phrase like, "What questions do you have?" instead of a blunt, "Do you have any questions?" For nonverbal communications, use simple pictures and diagrams, and make sure that written materials are easy to read, with at least a 12 point font.

Lastly, you may need to employ a medically trained interpreter for patients with limited English proficiency or hearing impairments. This will ensure that important information is communicated accurately and is culturally appropriate.

Make sure they understand

"Does this make sense? Can you repeat back to me what you need to do?"

"Tell me in your own words how you will follow these instructions."

"So, how many times a day will you take your prescription?"

Use the "teach back" method, shown in the examples above, to evaluate the effectiveness of what you've communicated. Asking a patient to restate shared health information in his or her own words will confirm that the message you've given is the message that was received. It also helps empower the patient to take responsibility for a healthier outcome, one that truly engages them in a collaborative partnership.

TO LEARN MORE

See these resources on patient-centered care and effective communication.

- Culture, Language, and Health Literacy video from The Health Resources and Services Administration (HRSA) discusses how culture, language, and health literacy are imperative to effective health communication
- Effective Communication Tools for Health Care Professionals, free online course from HRSA
- Health Literacy Universal Precautions Toolkit from the Agency for Healthcare Research and Quality (AHRQ) helps primary care teams assess their health literacy services and raise awareness of the staff
- AHRQ. Patient Centered Medical Home Resource Center. *www.ahrq.gov/professionals/systems/primary-care/pcmh/index.html*
- National Patient Safety Foundation. Ask-me-3. *www.npsf.org/for-healthcare-professionals/programs/ask-me-3/*
- Patient Fact Sheet: Five Steps to Safer Health Care (AHRQ) is targeted to health care consumers

According to the National Assessment of Adult Literacy, nearly nine out of 10 adults do not have proficient health literacy, and many lack the skills needed to manage their health and prevent disease.

This article originally appeared in the Fall 2013 issue of Brink, a quarterly risk solutions magazine published by MMIC. For more information, visit MMICgroup.com.

New Members 2013
Welcome to the NDMA!

Name	City	Specialty
Edward L. Adams, MD	Grand Forks	ORS
Ryan J. Agema, MD	Fargo	EM
Mohammed M. Alam, MD	East Grand Forks	FM
Minhal H. Alhashim, MD	Grand Forks	D
Noor Azreen Ali, MD	Minot	FM
Albert P. Allick, MD	Fargo	P
Oksana I. Anand, MD	Fargo	GE
Samuel O. Anim, MD	Fargo	PHO
Gregory G. Ausmus, MD	Fargo	DMP
Mohamad K. Baaj, MD	Minot	FM
Varsha Babu, MD	Fargo	IM
Ramesis Bacolod, MD	Grand Forks	FM
Amanda J. Beehler, DO	Fargo	D
Peter Biegler III, MD	Fargo	DR
Zhanyong Bing, MD	Fargo	ATP
Michael J. Blankinship, MD	Fargo	D
Jill M. Briggs, MD	Fargo	HOS
Maximo O. Brito, MD	Fargo	ID
Anthony N. Brown, MD	Fargo	ORS
Michael Ray Brown, MD	Bismarck	CDS
Jeremy F. Brudevold, DO	Fargo	EM
Melanie M. Brumwell, MD	Fargo	AN
Sree Budati. MD	Grand Forks	FM
Joni L. Buechler Price, MD	Fargo	RO
Brad R. Buell, MD	Fargo	OTO
Jantey Carey, MD	Fargo	HOS
Kari A. Casas, MD	Fargo	MG
Luis Casas, MD	Fargo	END
Vijay Chaudhary, MD	Bismarck	ON
Chris L. Cleveland, MD	Fargo	PD
Manuel Colon-DeJesus, MD	Fargo	AN
Christopher DeCock, MD	Fargo	NP
Stephanie M. Delvo, MD	Bismarck	OBG

Name	City	Specialty
Khalin F. Dendy, MD	Bismarck	IM
Taylor F. Dowsley, MD	Fargo	CD
Cornelius M. Dyke, MD	Fargo	TS
Kwame D. Eagleton, MD	Grand Forks	AN
Andrea M. Eickenbrock, MD	Grand Forks	OBG
Rachel M. Fleissner, MD	Fargo	P
Stephanie Foughty, MD	Grand Forks	FM
Christopher S. Fukuda, MD	Bismarck	U
Kristina L. Garrels, MD	Fargo	U
Karyssa A. Gibbs, MD	Fargo	FM
Randolph D. Gibbs, MD	Fargo	HS
Steven K. Glunberg, MD	Detroit Lakes	FM
Alicia A. Glynn, MD	Fargo	EM
Vikesh Gupta, MD	Grand Forks	CCM
Nader Habli, MD	Fargo	AN
Nathaniel L. Hall, MD	Fargo	ICD
Samy Heshmat, MD	Fargo	U
April A. Hess, MD	Fargo	HOS
Nicholas A. Hoskins, MD	Bismarck	AN
Sara N. Houston, MD	Fargo	PD
Chris Irmen, MD	Grand Forks	FM
Adam W. Jackson, MD	Fargo	NS
Diosdado T. Jaramillo, MD	Bismarck	AN
Kara J. Johnson, MD	Fargo	PUD
Katherine Joseph, MD	Grand Forks	FM
Prakash Kafle, MD	Fargo	ID
James G. Kappenman, MD	Fargo	OBG
Samantha S. Kapphahn, DO	Fargo	CD
Jeffrey R. Keim, MD	Fargo	PS
S.M. Farhan Khan-Galzie, MD	Fargo	U
Robyn Knutson Bueling, MD	Fargo	FM
Bradley W. Kohoutek, MD	Fargo	P

New Members 2013
Welcome to the NDMA!

Name	City	Specialty
Karol Z. Kremens, MD	Fargo	CCM
Corey J. Kroetsch, MD	Fargo	GS
Paulina J. Kunecka, MD	Fargo	IM
Mark Larkins, MD	Grand Forks	NS
Joshua LeClaire, DO	Fargo	CLP
Collette R. Lessard-Anderson, MD	Grand Forks	OBG
Hung Kei Li, MD	Fargo	CAE
Aaron L. Luebke, MD	Bismarck	HEM
Jay M. MacGregor, MD	Fargo	CRS
Sathyanarayana M. Machani, MD	Fargo	IM
Sanju Mahato, MD	Minot	FM
Devendranath R. Mannuru, MD	Fargo	HOS
Kristine E. Martens, DO	Fargo	FM
Saif A. Mashaqi, MD	Fargo	SMN
Clifford T. Mauriello, MD	Fargo	PD
Denise M. McDonough, MD	Mandan	FM
Matthew J. McLeod, MD	West Fargo	FM
Michael A. Mirzai, MD	Bismarck	CHP
Ramesh Mishra, MD	Grand Forks	PD
Rafiyath S. Mohammed, MD	Fargo	ON
Monika Moni, MD	Minot	FM
Prashant Morolia, MD	Minot	FM
Jennifer L. Mullally, MD	Fargo	PD
Eugeniu V. Muntean, MD	Fargo	N
Avish Nagpal, MD	Fargo	ID
Brook V. Nelson, MD	Dickinson	GS
Jeffrey J. Nelson, MD	Bismarck	OTO
Rebecca K. Novacek, MD	Grand Forks	N
Prince Pannu, MD	Minot	FM
Shahmohammed F. Parves, MD	Fargo	AN

Name	City	Specialty
Mahesh Patel, MD	Bismarck	NPM
Navin Paul, MD	Fargo	GE
Hong Q. Peng, MD	Fargo	ATP
Jedidiah J. Perkerewicz, MD	Fargo	OBG
Maritza Proano, MD	Fargo	GE
Elena R. Raducu, MD	Bismarck	OPH
Carrie Ann Ranum, MD	Hettinger	PD
Karim B. Rashid, MD	Fargo	AN
Garett A. Rhule, MD	Williston	NEP
Heather L. Rusten, DO	Grand Forks	IM
Joyoti Saha, MD	Fargo	OBG
Ravinda Samaraweera, MD	Fargo	N
Prasad J. Sawardeker, MD	Fargo	ORS
Subhechchha Shah, MD	Grand Forks	FM
Kamille S. Sherman, MD	Grand Forks	FM
Eric Siegel, MD	Fargo	OBG
Tanya L. Skager, MD	Dickinson	FM
Vitaliy Starosta, MD	Fargo	HOS
Christina M. Tello Skjerseth, MD	Bismarck	DR
Priyanka Tiwari, MD	Fargo	GE
Sumit Tiwari, MD	Fargo	CD
Todd Twogood, MD	Bismarck	PD
Irminne E. Van Dyken, MD	Grand Forks	GS
Peter Van Eerden, MD	Fargo	MFM
Diane Voeller, MD	Grand Forks	FM
Matthew L. Voigt, MD	Bismarck	AN
Matthew E. Wiisanen, MD	Fargo	ICD
Andrew J. Wilder, MD	Bismarck	DR
William F. Wosick, MD	Fargo	DR
Rebecca M .Ziegler, MD	Fargo	DMP

We'll keep you in the loop while you focus on all the important stuff.

At MMIC, we believe physicians are most at ease when they are up to snuff on the latest patient safety solutions. We attend the latest conferences, ardently track legal trends and promote best practices far and wide. That way, physicians can focus on what matters most: the patient.

MMIC

To join our health care revolution, contact your independent agent or broker or visit PeaceofMindMovement.com to see what MMIC can do for you.

2014 Events Calendar

April 22-24, 2014

National Rx Drug Abuse Summit
Atlanta, GA

For more information, contact
Cheryl Keaton at 606-657-3218
or go to
www.NationalRxDrugAbuseSummit.org

April 25-26, 2014

North Dakota and South Dakota
Chapter of the American College of
Surgeons 2014 Annual Meeting
Holiday Inn – City Centre
Sioux Falls, SD

For more information, contact the
ND Chapter office at 701-223-9475

May 10, 2014

University of North Dakota School
of Medicine and Health Sciences
Graduation Commencement
Grand Forks, ND

For more information, contact the
UND SMHS office at 701-777-3000

May 18-21, 2014

American College of Emergency
Physicians Leadership and Advocacy
Conference
Omni Shoreham Hotel
Washington, DC

June 7-11, 2014

American Medical Association House
of Delegates Annual Meeting
Hyatt Regency Hotel, Chicago, IL

For more information,
call 701-223-9475

June 18-20, 2014

Dakota Conference on Rural and
Public Health, Alerus Conference
Center, Grand Forks, ND

For more information,
call Kylie Nissen at 701-777-5390

July 15-16, 2014

2014 North Dakota State
Immunization Conference
Ramkota Hotel, Bismarck, ND

For more information, go to
their website at *www.und.edu/*
conference-services/immunization

July 25, 2014

North Dakota Board of Medical
Examiners Board Meeting
Bismarck, ND

For more information,
call 701-328-6500

August 7-9, 2014

American Medical Association State
Advocacy Roundtable
Conrad Chicago, Chicago, IL

For more information,
call 701-223-9475

September 5-6, 2014

North Dakota Society of Obstetrics
and Gynecology
Ramkota Hotel, Bismarck, ND

For more information, contact
Dennis Lutz, M.D. at 701-852-1555

September 22-24, 2014

2014 Harold Rogers Prescription
Drug Monitoring Program National
Meeting
Marriott Metro Center
Washington, DC

For more information, go to their
website at *www.pdmpassist.org*

October 3, 2014

NDMA Annual Meeting
Grand Forks, ND

For more information, contact the
NDMA office at 701-223-9475

October 7-9, 2014

North Dakota Hospital Association
Annual Meeting and Trade Show
Hilton Garden Inn, Fargo, ND

For more information, contact
Lori Schmautz at 701-224-9732

November 8-11, 2014

American Medical Association House
of Delegates Interim Meeting
Hilton Anatole, Dallas, TX

For more information,
call 701-223-9475

November 14-15, 2014

North Dakota Academy of Family
Physicians Annual Meeting
Grand Forks, ND

Contact Brandy Jo Frei at
701-772-1730 or brandy@ndafp.org

November 21, 2014

North Dakota Board of Medical
Examiners Board Meeting
Bismarck, ND

For more information,
call 701-328-6500