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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.

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Katie Fitzsimmons, Editor

In this Issue

Physician Advocate

Meaningful Influence

Courtney Koebele, NDMA executive director, and I had the recent opportunity to represent North Dakota's physicians in Washington, D.C. during the AMA National Advocacy Conference. While these two associations (NDMA and AMA) are completely distinct entities, NDMA does attend and support select AMA policy and events. I like to refer to it as the leeching of specific resources that are useful for physicians in North Dakota.

A strong focus of the advocacy efforts of your NDMA centered on Meaningful Use (MU). While MU falls under the regulatory landscape of the Centers for Medicare & Medicaid Services (CMS), Congress has significant influence on the CMS administration. Your NDMA's focus was to encourage North Dakota Senators and Congressman to act this year to implement Meaningful Use reform.

Wouldn't it be refreshing if the top priority of electronic health records was to perform as a clinical tool for patient care and not a billing, coding, and data mining service? Would it be helpful to have vendors develop truly interoperable platforms, with a single sign-on embedded within the EHR, for prescription drug monitoring programs, immunization registries, prior authorization determinations, accurate formulary coverage, and medication fill rates? Would it be reasonable for MU to provide partial credit if eligible providers met 75% of the criteria, rather than being an all or nothing program?

Sound like a pipe-dream? Maybe... or maybe not. In January, the CMS Acting Administrator Andy Slavitt stated: "The Meaningful Use program as it has existed, will now be effectively over and replaced with something better." This offers a glimmer of hope that MU is not written in stone and more importantly, that physician input is being heard and valued for future reforms.

So how does a lowly primary care doc in Jamestown, North Dakota influence a policy as monstrous as MU? By being an active member in NDMA and calling you to action to do the same. Courtney and I were charged with reporting back on what physicians felt were the top five most burdensome meaningful use regulations. While the AMA already has well-written and specific recommendations for improving MU, I want to hear from you. As I pledged when I became your NDMA president, my role is to listen and convey your message. So let me hear it.

Deb.geier@outlook.com
701-659-1719

I want to hear your top five calls for change in the Meaningful Use program. Send me your candid comments- I will even offer to edit them for you. Identify those requirements that add only documentation time and do not add value to patient care. We as physicians interact with IT as much or more as we do with patients on any given day. The front-line needs of physicians and patients are instrumental to building systems that work together to seamlessly exchange information and support health care decision making.

Debra Geier, MD, NDMA President

Wouldn't it be refreshing if the top priority of electronic health records was to perform as a clinical tool for patient care and not a billing, coding, and data mining service?

The front-line needs of physicians and patients are instrumental to building systems that work together to seamlessly exchange information and support health care decision making.

Qui tacet counsentiret
"Silence gives consent"

There should be no silence on the biggest intruder in the patient-physician relationship. Use your influence.

I look forward to hearing from you.

The Problem with Opioids

Courtney M. Koebele, JD

The Opioid issue is everywhere.

Opioids are a class of drug that includes both natural and synthetic drugs such as morphine and codeine, Vicodin, Percodan, oxycodone, and heroin. According to the American Society of Addiction medicine, drug overdose is the leading cause of accidental death in the United States, with 47,055 lethal drug overdoses in 2014. Opioid addiction is behind this epidemic, with 18,893 overdose deaths related to prescription pain relievers and 10,574 overdose deaths related to heroin in 2014.

In 2012, 259 million prescriptions were written for opioids, which is more than enough to give every American adult their own bottle of pills.

From 1999 to 2008, overdose death rates, sales, and substance use disorder treatment admissions related to prescription pain relievers increased in parallel. The overdose death rate in 2008 was nearly four times the 1999 rate; sales of prescription pain relievers in 2010 were four times those in 1999; and the substance use disorder treatment admission rate in 2009 was six times the 1999 rate. In 2012, 259 million prescriptions were written for opioids, which is more than enough to give every American adult their own bottle of pills.

The President's 2017 budget takes a two-pronged approach to address this epidemic. First, it includes $1 billion in new funding over two years to expand access to treatment for prescription drug abuse and heroin use. Secondly, the budget includes approximately $500 million - an increase of more than $90 million - to expand state-level prescription drug overdose prevention strategies, increase the availability of medication-assisted treatment programs, improve access to the overdose-reversal drug naloxone, and support targeted enforcement activities.

How is North Dakota doing? According to the Department of Human Services statistics, the Human Service Centers treated 2,642 adults and 252 youths in the last three months of 2015 for chemical dependency (private facilities do not submit their treatment numbers) and adult heroin use is rising, whereas youth use has remained the same and is quite low. The North Dakota Department of Health, Division of Vital Records, reports that there were 25 reported deaths from drug use in 2010, 27 in 2011, 33 in 2012, 32 in 2013 and 27 in 2014. Unfortunately, reported deaths may not be accurate because of the way reporting is completed. NDMA is part of a task force to address this issue.

This issue has the nation's attention. In February, the National Association of Governors issued a joint statement with the American Medical Association declaring: "To end this national epidemic that claims the lives of so many of our family members and fellow citizens, governors, physicians, state legislatures and other stakeholders must join together to take action." Actions recommended include appropriately funding PDMPs, education throughout the career of physicians, and prioritizing treatment for substance use disorder.

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Just this month, the United States Senate passed the Comprehensive Addiction and Recovery Act (CARA) of 2015 by a vote of 94-1. This legislation was the product of nearly three years of work across the aisle. The bill changes the emphasis from abstinence only treatment to

focusing more on medication. It provides funding for support to educational efforts to prevent the abuse of opioids, endorses the understanding of addiction as a disease and the promotion of treatment and recovery, promotion of civil liability protections for the administration of naloxone, promotion of drug take-back sites, and building communities of support for people in recovery.

There is not a meeting regarding health care policy where opioid addiction is not discussed. North Dakota state policy makers have been talking about opioids for several sessions. In 2011, the legislature reviewed a proposal to require WSI patients and physicians to go through a complicated set of protocols. That effort was defeated. However, legislators and regulators continued to look at North Dakota Prescription Drug Monitoring Program (PDMP) as a useful tool. Unfortunately, the rate at which physicians (and other providers) are signing up and using the PDMP is low. Approximately 30% of physicians are currently signed up for the PDMP. According to the most recent numbers from the North Dakota Board of Pharmacy, only 283 physicians submitted requests in the fourth quarter of 2015.

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Therefore, in 2015, the legislature passed a bill directing all state licensing boards to enact administrative rules governing the use of the PDMP. It is their strong expectation that sign up will be mandatory and use required under certain situations.

The North Dakota Board of Medicine is in the process of enacting rules for the use of the PDMP pursuant to this directive from the state legislature. All other state licensing agencies will also be enacting rules. The Board of Medicine rules will be approved at its July meeting, with public hearing and comment in the weeks following the meeting. The rules will then be forwarded to the legislative administrative rules committee to review.

Once the rules are finalized, we will be communicating the details to all physicians. However, the most significant aspects that will affect your practice:

NDMA continues to work closely with the Board of Medicine to develop rules that will allow physicians to use the PDMP without interfering with the day-to-day workflow.

- Sign up for PDMP will be mandatory for every practitioner with a DEA number
- A report shall be requested if drugs will be prescribed for a period to exceed 12 weeks
- The report is not required if patient has cancer, is in hospice care, or is in a hospital or nursing home

NDMA continues to work closely with the Board of Medicine to develop rules that will allow physicians to use the PDMP without interfering with the day-to-day workflow. In addition, work continues on linking license numbers to the PDMP, so sign-up will be as seamless as possible.

If you have any questions about the rules, please feel free to contact me at the NDMA office at 701-223-9475. You can sign up for the PDMP at the Board of Pharmacy online: *www.nodakpharmacy.com/directaccess.asp.*

Challenges and Opportunities

News from the Dean of the UND SMHS

Joshua Wynne, MD, MBA, MPH

This is a time both of excitement—regarding the opening of the new building and the many accomplishments of our students, faculty, and researchers—and some circumspection and reflection given the budget challenges that the state is facing. As you undoubtedly know, North Dakota's revenue collections to support state agencies are about a billion dollars below target, and the School, like all other institutions in higher education, needs to reduce our expenditures to help bring the overall budget into balance. That means that we need to identify about $5.6 million in our current operating budget to return to the state out of our remaining 2015–17 allocation, which amounts to around $50 million. That's about an 11 percent cut, although a little less than half of it will be a one-time adjustment. But at this point, there is little reason to think that the budget trimming this biennium won't continue to be required for the 2017–19 biennial budget that the Legislature will begin debating and preparing less than a year from now. So the cuts are real, and likely to be a factor for the foreseeable future.

To be sure, we will—we must—live within our means, and that means delivering a balanced budget.

What are the implications for the School's various educational, research, and service-oriented programs? It is clear that we will need to make some hard choices and will face difficult decisions. But what the School will resist doing to the maximum extent possible is an across-the-board type of budget-balancing approach. Rather, we will be selective and mission-oriented in deciding between the various options that will face us. To be sure, we will—we must—live within our means, and that means delivering a balanced budget. We will look for any and all opportunities to increase efficiency, achieve economies of scale, and maximize value. But in my opinion, we already run a pretty tight ship; however, we will need to identify—and probably downsize or eliminate—those components of our programs that return less value than others. It will necessitate some real pain and affect some of our colleagues. After all, almost three-quarters of the School's budget is composed of personnel costs (salary and fringe benefits), so it is not going to be possible to achieve this magnitude of budget cut without directly affecting some people. Nevertheless, to put the budget situation in some focus, state appropriations account for a little over a third of our overall budget. So a budget cut of even 11 percent for the remainder of the current biennium amounts to a reduction of less than 4 percent of our entire budget—still real money but not the end of the world! We will work through this challenge, and continue to deliver outstanding educational programs, high-quality scholarship and research, and service to North Dakota and the region.

And perhaps nothing is more symbolic of that commitment to the well-being of North Dakota and North Dakotans than the new building, which is nearing completion. The building should be substantially complete by mid-May, with a projected opening date of July 15, 2016—just in time for the incoming medical school class of 2020 along with arriving freshman in the various health sciences programs. Mark your calendars for the grand opening celebration for the building that will take place during UND Homecoming 2016. The official ceremony will begin at 1:00 p.m. on Friday, October 14, 2016, to be followed by directed tours of the building. We anticipate a most memorable and noteworthy event, and one that ushers in a new era of healthcare workforce preparation and training.

After all, training future healthcare providers is the School's fundamental focus. That's why I was especially pleased to hear recently from the Liaison Committee on Medical Education (LCME), the agency that accredits the medical education programs of schools in the United States and Canada. The LCME complimented the School on the way we addressed the previously noted citations, and put us back on the regular cycle of review. While there are four specific areas where the LCME wants to have some further information and data from us by

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December 1, 2016, we anticipate no problem in complying. Importantly, we no longer have the "warning" label associated with us, remain fully accredited and in good status, and our next LCME visit will be in 2022.

And based on changes that we've made to our entire accreditation process, I anticipate that future visits by the LCME survey team (beginning in 2022) will be less stressful than before. The major change is that we now incorporate accreditation preparation and compliance activities into our routine curricular management process (rather than waiting to prepare for an LCME visit in the one or two preceding years). Under the overall direction of Assistant Dean for Medical Accreditation and Chief Medical Accreditation Officer Dr. Stephen Tinguely, our LCME-related activities are ongoing, iterative, and continuous. We are in a minority (but increasing number) of schools that now handle things in this proactive and forward-looking manner, but looking back, one has to wonder why almost all schools (ours included) handled accreditation visits the way we did in the past. As a matter of fact, the LCME now requires medical schools to show evidence of continuous quality improvement, which is interpreted to mean that schools show how they are addressing LCME accreditation standards on an ongoing basis.

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The positive LCME review is yet another indication of the value that the School delivers. The main reason that I'm so optimistic about the future of healthcare in North Dakota—even given our current budget woes—is that through the Healthcare Workforce Initiative (HWI), we have a plan for beginning to address our healthcare workforce issues. It will not be the entire answer. We will continue to struggle to deliver high-quality accessible healthcare to various rural communities in the state. But unlike many other states, at least we have a plan that already has begun to help. Because of the budget situation, it is likely that we'll have to scale back or delay some of the provisions of the HWI. But the essence of it will continue to be implemented, and should positively address the state's long-standing healthcare delivery challenges.

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So despite the news about the economy, I remain excited and upbeat about the healthcare situation in North Dakota. While we are not immune to the national—let alone worldwide—triple healthcare challenges of cost, quality, and access, I am confident that we are on a path to dealing more effectively with those challenges—even in a budget-challenged future. I look forward to continuing to work with our students, faculty, staff, and stakeholders from around the state—especially those of you who are clinical faculty members at the School and help us to educate the next generation of physicians—to design and deliver a brighter healthcare future.

MACRA and MIPs...
Much More Than Just a New Set of Acronyms!

The Medicare Access & CHIP Reauthorization Act of 2015 (MACRA), also known as "the doc fix" bill, was signed into law with little fanfare in April 2015. However, beginning in 2019, provisions within MACRA will have a significant impact on how physicians and clinicians are paid and will drive changes in healthcare delivery towards systems of care that improve quality, improve health, and lower costs.

Until now, the transition away from volume-based reimbursement and towards payment based on value has been happening incrementally through a variety of programs such as PQRS, Value-Based Modifiers, and Meaningful Use. Under MACRA, all of the payment adjustments associated with these programs will sunset and will be consolidated into a single program known as the Merit-Based Incentive Payment System or MIPS.

While there are still many details being finalized through the proposed rulemaking and public comment process, some key elements of MIPs are known. In the first two years (2019 – 2020), MIPS incentives and penalties will apply to physicians, PAs, CRNAs, NPs, and Clinical Nurse Specialists. These eligible clinicians will receive a Composite Performance Score (0-100) based on performance in four weighted categories: quality, resource use, clinical practice improvement activities, and meaningful use of certified EHR technology. These scores will be linked to significant payment adjustments that will increase over time. Clinicians will receive an upward, downward, or no payment adjustment based on their Composite Performance Score.

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Eligible clinicians who participate in qualified Alternate Payment Models (APMs), may be exempt from MIPS. Under a qualified APM, clinicians would not be subject to MIPs incentives or penalties, but instead, by meeting all requirements, would receive 5% lump sum bonus payments for years 2019-2024, and receive a higher fee schedule update for 2026 and beyond.

We don't yet know how the transition to MACRA and MIPs will impact healthcare payment and healthcare delivery in rural areas of our state. MACRA contains language that references some "low volume threshold exclusions"; what that means still needs to be clarified.

In a report entitled "Medicare Value-based Payment Reform: Priorities for Transforming Rural Health Systems" released by the Rural Policy Research Institute (RUPRI) in November 2015, the authors acknowledge that many of the policies and programs that have been put in place to ensure access to healthcare in rural and underserved areas of the country (e.g. RHCs, CAHs) are now barriers to participation in new value-based payment programs. The report states that "rural provider inclusion in payment and delivery system changes is crucial if health equity is to be achieved" and makes several recommendations for the implementation of policies to accompany these changes that "recognize the special circumstances facing rural providers."

In addition, Heidi Heitkamp and four other members of the bipartisan Rural Health Caucus recently wrote a letter encouraging CMS to "incorporate the unique realities of rural settings" as they develop and implement the details of MACRA.

The proposed MACRA/MIPs rule is scheduled to be published in July 2016, with the Final rule to follow by November 2017. 2019 is just a few short years away and the payment adjustments that occur in 2019 will be based on a one or two year look-back, so making change now should be a priority. Clinicians will be best positioned for success under MIPs by transforming the way they deliver health care now. This includes becoming certified Patient-Centered Medical Homes, managing care for patients with chronic disease, using data to monitor and improve quality of care, focusing on improving patient outcomes, engaging patients and families in their care, and reducing unnecessary tests and hospitalizations.

Barbara Groutt, Chief Executive Officer, Quality Health Associates of North Dakota

To help practices prepare for MIPS, the Centers for Medicare & Medicaid Services recently funded twenty-nine Practice Transformation Networks (PTNs) who are responsible for providing technical assistance to physician practices to achieve transformation goals. At the present time, two PTNs are available to work with practices in North Dakota; COMPASS/HealthPoint and National Rural Accountable Care Consortium. We encourage you take advantage of this opportunity for free assistance. You can review the benefits of each PTN on their websites and contact them for additional information, or you can contact Tracey Regimbal at Quality Health Associates via e-mail at tregimbal@qualityhealthnd.org.

Keith J. Mueller, PhD, et al., "Median Value-Based Payment Reform: Priorities for Transforming Rural Health Systems," http://www.rupri.org/wp-content/uploads/FORHP-comments-km-DSR-PANEL-DOCUMENT_PRD_Review_112315.clean-4_sn-3.pdf, (November 2015).

Tobacco Tax - A Winning Solution

AMERICAN LUNG ASSOCIATION. IN NORTH DAKOTA

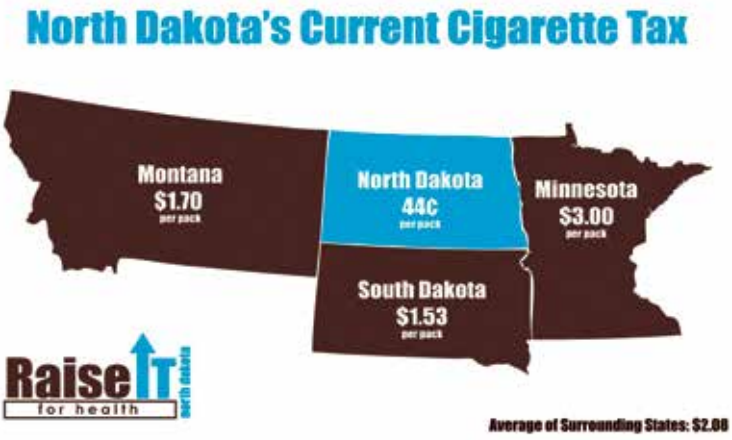
Kristie Wolff, Program Manager,
American Lung Association in North Dakota

In February 2016, the American Lung Association released its 14th annual "State of Tobacco Control" Report. This report tracks progress on proven-effective tobacco control policies being enacted, or ignored, at the federal and state level. Grades are assigned in a variety of areas: strength of smoke-free laws, access to cessation services, support for comprehensive tobacco-prevention programs, and level of tobacco taxes; and are based on whether these policies are adequately protecting citizens from tobacco-related death and disease.

Amidst otherwise good "grades", North Dakota received an "F" for its current tobacco tax rates. At only 44 cents per pack, North Dakota's cigarette tax is among the lowest in the nation, a tax rate that has remained at that level since its last increase in 1993.

Why Support Higher Tobacco Taxes?

Tobacco tax increases are one of the most effective ways to reduce smoking and other tobacco use, and even more importantly, keep our kids from ever starting.



For decades, data has long shown that when tobacco prices increase,

- fewer people use tobacco,
- people who continue to use tobacco consume less,
- people who have already quit are less likely to start again, and
- young people are far less likely to ever start using tobacco.

Tobacco taxes are widely accepted by the public and even supported by many tobacco users. Statewide public polling consistently shows this to be true here in North Dakota. When asked, fellow North Dakotans, regardless of age, gender, political affiliation, or geography, overwhelming support tobacco prevention and control policies, including efforts to increase tobacco taxes.

How Do We Compare?

The national average of state cigarette excise taxes is currently $1.61 per pack, and individual state rates vary widely, from just 17 cents per pack in Missouri to $4.35 per pack in New York.

To give a better reflection of current rates regionally, North Dakota still remains significantly lower than our neighboring states:

- South Dakota - $1.53/pack
- Montana - $1.70/pack
- Minnesota - $3.00/pack

This "neighborly average" amounts to $2.08 per pack, putting North Dakotans, especially North Dakota kids, at a much higher risk of tobacco initiation, addiction, disease, and even death.

What's the Cost of Tobacco in ND?

While the average retail price in the United States for a pack of cigarettes is $5.96 per pack, smoking-caused health care costs and productivity losses associated with just one pack of cigarettes is estimated to be a minimum of $19.16 per pack. That cost difference is often covered by non-tobacco using taxpayers. Higher tobacco taxes save money by reducing tobacco-related health care costs, including Medicaid expenses, over the long-term.

The true costs of tobacco use, however, reaches far beyond the monetary costs. Smoking continues to kill more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined, and thousands more die from other tobacco-related causes, such as fires caused by smoking (more than 1,000 deaths each year nationwide).

These numbers don't lie:
North Dakotan adults who die each year from their own smoking: **1,000**
Annual health care costs in North Dakota directly caused by smoking: **$326 million**
Portion covered by the state Medicaid program: **$56.9 million**
Residents' state & federal tax burden from smoking-caused government expenditures: **$823 per household**
Smoking-caused productivity losses in North Dakota: **$232.6 million**
(Amounts do not include health costs caused by exposure to secondhand smoke, smoking-caused fires, smokeless tobacco use, or cigar and pipe smoking.)

Raise IT for health north dakota

Having one of the lowest tobacco taxes in the nation is not an award worth earning. Our state can achieve significant health and revenue gains by increasing tobacco taxes on cigarettes and other tobacco products like smokeless tobacco and cigars. It is time to raise the tobacco tax for the health of our citizens and to effectively protect our youth from a lifelong addiction to nicotine and the deadly consequences of tobacco. Please talk to your local, state, and federal officials about the impacts of low tobacco taxes and what they can and will do to move North Dakota's "F" grade to an "A."

Source: WHO Report on the Global Tobacco Epidemic, 2008. The MPOWER package. Geneva, World Health Organization, 2008. Campaign for Tobacco Free Kids, www.tobaccofreekids.org. American Lung Association State of Tobacco Control 2016.

IN MEMORIUM

Honoring members of the North Dakota Medical Association who passed away in 2015

Mariquita R. Cansino-Lim, MD

Rodolfo C. Carriedo, MD

Perry Engstrom, MD

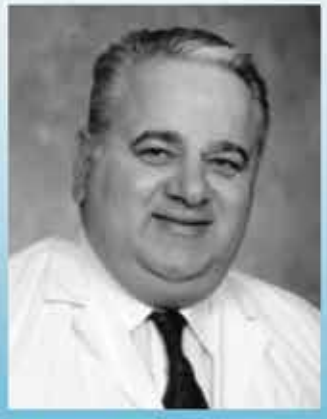
Gualberto C. Gokim, Jr., MD

Robert L. Jennings, MD

Alan G. Kenien, MD

O. Victor Lindelow, MD

John Sawchuk, MD



Daniel D. Schmelka, MD

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

-Hippocrates

Physicians Identify Ways to Improve Opioid Overdose Prevention

From the American Medical Association

A national physician survey released in February shows strong support for key policies and recommendations to end the nation's opioid epidemic, including ways to improve prescription drug monitoring programs (PDMP), enhancing physician education, and removing barriers to care. Learn what physicians said and resources that are available to help advance their efforts.

The survey, which was commissioned by the AMA and the AMA Task Force to Reduce Prescription Opioid Abuse[1], had several key findings:

- **PDMPs can be valuable tools:** 87 percent of physicians agree that PDMPs help them become more informed about a patient's prescription history. Physicians who aren't already registered to use their state's PDMP can easily find how to do so through the task force resource pages[2], which include links directly to the state databases and education materials on how physicians can use PDMPs to enhance clinical treatment.

- **PDMPs need changes to be more beneficial:** Physicians said that PDMPs would be much more helpful if they were improved to integrate with electronic health records, provide real-time data, and other key features that would make them even more useful.

The AMA task force is urging states to ensure these and other important features[3] are part of their PDMPs.

- **Physicians are educated but want more specific continuing medical education (CME):** 68 percent of survey respondents said they have taken CME on safe opioid prescribing, and 55 percent have taken CME on managing pain with opioid alternatives. But the survey found that physicians are seeking more practice-specific and specialty-specific education, with 1 in 4 physicians saying the CME they needed was not readily available.

The task force offers a full collection[4] of the most up-to-date state and specialty-specific education resources so physicians can easily find the materials they need.

In addition, several medical organizations offer waiver-qualifying medication-assisted treatment (MAT) training[5] to help physicians recognize patients with substance use disorder and become certified to increase access to treatment.

- **Significant barriers exist to non-pharmacologic and non-opioid treatments:** Physicians said the main barriers to using alternatives to opioids include a lack of coverage by insurance companies, difficulty finding a specialist to which they can refer their patients for pain treatment, and pressures to ensure they achieve a high patient satisfaction score.

- **Physicians strongly support co-prescribing naloxone:** More than 80 percent of physicians said that naloxone should be available to a patient at risk of an overdose via a standing order or collaborative practice agreement with a pharmacist. The AMA offers model legislation that includes support for standing orders and also has supported more than 20 state laws that increase access to naloxone in the community.

Physicians can access additional information about naloxone[6] from the task force and download recommendations for co-prescribing.

"This survey provides an important window into physicians' perceptions about caring for patients with pain and those with substance use disorders," AMA President Steven J. Stack, MD, said in a press release[7]. "This survey confirms that physicians support many of the key policies being considered to end this crisis. The AMA and the nation's physicians are committed to partnering with others to implement proven solutions."

Physicians support many of the key policies being considered to end this crisis. The AMA and the nation's physicians are committed to partnering with others to implement proven solutions.

The survey was conducted for the AMA by TNS Global Research between November 13 and 23, 2015. The sample size was 2,130 practicing physicians who provide a minimum of 20 hours per week in direct patient care, have a current Drug Enforcement Administration license to prescribe Schedule II controlled substances, and prescribe opioids at least on a weekly basis. The sample included all practice settings and regions in the United States.

How physicians can turn the tide of the opioid epidemic

Also in February, the nation's physicians received a direct appeal[8] from AMA President Steven J. Stack, MD, urging them to take swift action to end the opioid epidemic that has claimed more than 250,000 lives over the past 15 years.

"We have a defining moment before us—the kind of moment that we will look back on in years to come as one in which we as a profession rose to the challenge to save our patients, our families, and our communities during a time of crisis," Dr. Stack wrote.

He likened this epidemic to the HIV/AIDS epidemic, in which policymakers, public health leaders, and physicians came together to implement solutions that changed the course of history for people with an HIV/AIDS diagnosis and their loved ones. He called on physicians to "mount a similar response" to the opioid epidemic.

"The loss of lives we are seeing around us and in the news every day is unacceptable—and we don't have to accept it," he wrote. "Each and every one of us must band together to take specific actions that will turn the tide."

He pointed to the five essential actions and resources for physicians that have been identified by the AMA Task Force to Reduce Prescription Opioid Abuse:

- Register for and use their state's prescription drug monitoring program (PDMP)
- Enhance their education and training about safe prescribing
- Co-prescribe naloxone to patients at risk of overdose
- Get training to provide medication-assisted treatment (MAT) for and help reduce stigma around substance use disorders
- Speak out against stigma[9] around patients in pain and the physicians who treat them

1. The AMA Taskforce to Reduce Prescription Opioids Abuse," http://www.ama-assn.org/ama/pub/advocacy/topics/preventing-opioid-abuse/opioid-abuse-task-force.page?, (March 2016).
2. Register for Your State PDMP," http://www.ama-assn.org/ama/pub/advocacy/topics/preventing-opioid-abuse/prescription-drug-monitoring-programs.page?, (March 2016).
3. Opioid Abuse is a Public Health Crisis," https://download.ama-assn.org/resources/doc/washington/15-0398-opioid-one-lawmaker.pdf, (March 2016).
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Tough Conversations

Talking to your patients and their families about advance directives

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Most people don't want to think about the end of life, much less talk about it. With advancing medical technologies, however, the end of life can often be a conscious decision as opposed to a predestined moment in time. Not talking about that decision before it arrives can cause unbearable distress – distress we can mitigate by discussing advance directives.

Shawn McGarry, a Utah defense attorney, has been through conversations about advance directives with clients and with his own family. "The fact that people create a will without advance directives is shocking to me," he says. He observes that people often seem to care more about how their belongings are distributed than alleviating the burden of end-of-life decisions on their loved ones.

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George Schoephoerster, MD, a family practitioner and geriatrician, engages in end-of-life discussions on a daily basis in nursing homes across central Minnesota. Dr. Schoephoerster describes an advance directive as a conversation about what a patient values and feels was the meaning of his or her life. This leads to decisions about when life is worth living and when to let go.

Advance directive

An advance directive or health care directive is a document expressing a patient's wishes concerning life-sustaining care if he or she becomes unable to make decisions. Any competent adult can and should complete a directive, not just those facing a terminal illness. A directive is where a patient expresses – while still able to think clearly – two important issues: first, what life-saving treatment he or she would choose (also covered by a living will); and second, who can make decisions on his or her behalf (also covered by a power of attorney or proxy). Patients can address either of these separately, but the advance directive usually encompasses both.

A patient can complete an advance directive on his or her own, and with or without help from a provider or an attorney. McGarry agrees that an attorney is usually not necessary. The critical issue is that "there has to be communication between and among family members." Dr. Schoephoerster, however, feels that as the end of life draws nearer, the provider should be involved so the directive can be more specific to the medical realities.

Living will

In a living will, a patient specifies what life-sustaining interventions he or she wants or does not want if certain events become a reality. This may include wishes about care, resuscitation, hospitalization, and under what circumstances the patient wants to live or to let go.

McGarry describes how his father's living will came from jokes about whether he wanted to live if he could only eat tofu. Funny scenarios led to serious scenarios and then to a written document. When his father's health deteriorated, "it alleviated the burden of having to face those questions," both for the family and for the providers involved. Knowing his father's wishes preempted any disagreement between family members and gave them peace.

Without a living will, McGarry believes the burden on his mother to make decisions would have been too much to bear. To illustrate, the living will directed that his father wanted extubation when it was clear he would not recover. When the tube was removed, however, his father seemed to struggle. "If my mom had been saddled with the decision to let him die, then for her to see him struggling to breathe... It would have been horrific for her. But we had a directive in place that said, 'If these certain things are present, then I don't want to live.'"

Power of attorney or proxy

A power of attorney, also called a proxy or health care agent, designates a loved one to manage a medical crisis, to communicate with providers, and to speak on a patient's behalf should he or she become incompetent.

Dr. Schoephoerster feels that a proxy is the most critical piece of any advance directive. He explains that living wills can be too vague to cover a specific, real-life scenario. A living will requesting "no heroic measures" leaves too much room for interpretation. As scenarios change, a proxy can look at the situation day to day and say, "Now this is what I think the person would want."

Providers hold enormous power to break down intimidation and start the conversation. Sharing talking points about options can lead families to face the harder part — talking about values in life, spiritual beliefs and their feelings about their humanity that will lead to decisions about end-of-life care.

Dr. Schoephoerster explains that a proxy can also take the provider out of the middle of feuding family members. The patient already selected one representative to speak on his or her behalf, and that person speaks for the whole family.

Physician order for life-sustaining treatment

The Physician Order for Life-Sustaining Treatment (POLST) is a standing and transferrable medical order completed by a physician that directs treatment in specific scenarios. The POLST functions as a do not resuscitate (DNR) order that can transfer between facilities, sometimes even between states. Unlike other directives, the POLST becomes appropriate at the end of life because it is effective immediately, not when some hypothetical circumstance arrives. It is used for patients with mental capacity, but who face life-threatening illnesses; patients with very specific, perhaps religious, preferences about end-of-life; and patients who want a DNR order outside of a health facility.

Dr. Schoephoerster explains that the POLST form has two advantages over other advance directives. First, it is an order from a physician. The physician is involved with the patient's care and is involved in the decision-making. Second, it is specific. The POLST is completed when medical realities are present, not hypothetical, and it addresses specifics of chronic disease management, resuscitation, hospitalization, and other real scenarios.

The National POLST Paradigm, an organization promoting POLST usage, estimates that 45 out of 50 states have existing or at least developing POLST programs.[1]

Start the conversation

Providers hold enormous power to break down intimidation and start the conversation. Sharing talking points about options can lead families to face the harder part – talking about values in life, spiritual beliefs, and their feelings about their humanity that will lead to decisions about end-of-life care.

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CaringInfo – National Hospice and Palliative Care Organization www.caringinfo.org
The National POLST Paradigm www.polst.org

This article originally appeared in the Fall 2015 issue of Brink, a quarterly risk solutions magazine published by MMIC. For more information, visit MMICgroup.com.

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2016 Events Calendar

April 12

6th District Medical
Society Meeting
Presentation:
Medical Marijuana
Kelly Inn, Bismarck, ND

April 21-23

North Dakota and South Dakota
Chapters of the American College
of Surgeons 2016 Annual Meeting
Watertown, SD

April 21-22

The Diabetes Summit
Radisson Hotel, Bismarck, ND
www.diabetesnd.org

April 30

North Dakota Orthopaedic
Society Annual Meeting
Courtyard by Marriott
Bismarck, ND

May 14-18

American Psychiatric Association
Annual Meeting
Atlanta, GA

May 16-18

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

Contact Kylie Nissen for more
information at 701-777-5380

May 23

American Cancer Society
Provider training for
CRC screenings
National Energy Center
of Excellence
Bismarck, ND

May 25

American Cancer Society
Provider training for CRC
screenings
Hilton Garden Inn
Fargo, ND

June 11-15

AMA Annual Meeting
Hyatt Regency Hotel
Chicago, IL

September 9

ND Society of Obstetrics and
Gynecology Annual Meeting
Ramada Plaza Suites
Fargo, ND

October 7

NDMA Annual Meeting
Hilton Garden Inn
Fargo, ND

October 14

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

If you would like more information on any of these events, please contact the NDMA office at 701-223-9475 or staff@ndmed.com