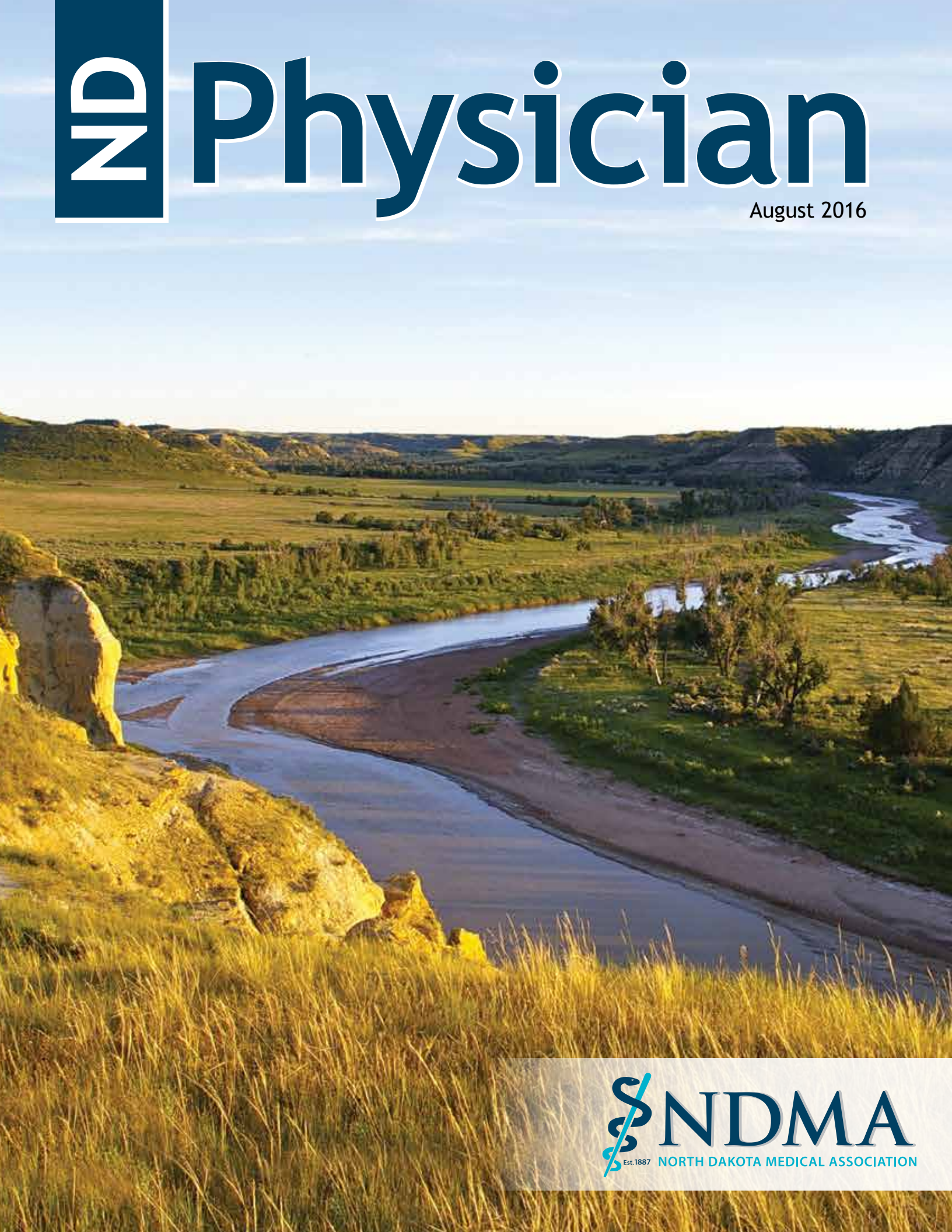
ND Physician

August 2016



NDMA
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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.

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.

Advertising
NDMA accepts one-quarter, one-half and full-page ads. Contact our office for advertising rates.

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Katie Fitzsimmons, Editor

In this Issue

Physician Advocate

"Completely devastated," "wreaking havoc," "a veritable nightmare"...

Debra Geier, MD, NDMA President

These are just a few headlines used to describe the economic downturn in many states, including North Dakota, as a result of the plunging price of oil. The nadir of the plunge resulted in oil prices at $26 per barrel in January 2016. This was well below the projections used by state officials to draft the current state budget. With the price of oil currently creeping upward but hovering around $50 per barrel, budget constraints will continue to be a hot topic for the foreseeable future. The pain of the transition from boom to bust and back again is not only being felt in the oilfields of western North Dakota, but in each and every corner of the state.

On February 1, Governor Jack Dalrymple ordered state agencies to make 4.05 percent across-the-board cuts to help partially offset the budget deficit. These cuts, referred to as the budget allotment, affected 73 state agencies including the Department of Human Services (DHS). Within the DHS, the budget allotment took a significant toll on the state's Medicaid program. Medicaid pays for health services for over 60,000 North Dakotans, many of whom are children. This also includes many of the most vulnerable and fragile members of our communities.

Now that the bust has arrived, the Medicaid budget has come under the knife...This resulted in a 32% cut to the Medicaid budget in three general areas: Medicaid fee schedule reimbursement, Medicaid professional fees, and Medicaid expansion.

Medicaid Past

Medicaid was authorized in 1966 to enable persons previously limited by their circumstances to receive needed medical care. The funding for Medicaid is shared by federal and state governments. Medicaid payment for these medical services has historically been very low. The 1980s and 1990s experienced a 22-year trend of policy decisions resulting in substantial under-funding of the actual costs necessary to ensure Medicaid access and quality throughout the state. In 2005-2006, the Budget Committee on Human Services, utilizing the actuary service of Milliman, Inc., estimated that North Dakota Medicaid physician payments were 44.27% of the billed amount. In the 2007-2009 budget session, the budget for all traditional Medicaid service providers was increased to 100% of Medicare rates with an annual inflator of 3%. The argument at the time was NOT that Medicare rates were sufficient to cover the cost of care. Quite the contrary, Medicare rates have been and continue to be approximately 50% of the actual cost of providing services. However, this was at least felt to be a starting point towards improved funding for the medical services of our Medicaid population. The partnership in advocacy between your North Dakota Medical Association and the North Dakota Hospital Association made this improvement possible.

The changes to the Medicaid budget, which are already in effect, will be felt in a comprehensive manner across our great state not only to Medicaid recipients but to all North Dakotans.

Medicaid Present

The 2009 adjustment to Medicaid payments has not been without scrutiny. In recent years, North Dakota has been in the top five states for Medicaid payment rates. During the boom times, the scrutiny was present but less intense. Now that the bust has arrived, the Medicaid budget has come under the knife. Although the budget allotment was technically a 4% cut to DHS, within the department, cuts to meet the allotment could be applied at will. This resulted in a 32% cut to the Medicaid budget in three general areas: Medicaid fee schedule reimbursement, Medicaid professional fees, and Medicaid expansion. Suffice it to say the headlines reading "completely

devastating" were not too far off the mark. Consider any business trying to survive a 32% cut to revenues.

The changes to the Medicaid budget, which are already in effect, will be felt in a comprehensive manner across our great state not only to Medicaid recipients but to all North Dakotans. In a state where the majority of physicians are employed by systems, very few facilities will, or have the option to, decline Medicaid patients. The impact of the budget allotment will not be felt through major changes to Medicaid access; it will be felt by all North Dakotans, privately insured, Medicare and Medicaid, through decreased healthcare options and choice. Some of the changes that are occurring as a result of the allotment include adjusting staffing ratios, eliminating non-revenue generating services, discontinuing capital investments, downsizing occupancy, closing units, and potentially even closing facilities. This is just the tip of the iceberg.

Medicaid Future

NDMA continues to advocate for Medicaid patients in North Dakota. NDMA has submitted a letter to DHS outlining concerns regarding the impact of the budget cuts. NDMA leadership has met with Governor Dalrymple in addition to the 2016 governor candidates to discuss their position on re-instating the Medicaid budget for 2017-2019. NDMA continues to partner with NDHA and plans to reach out to the legislative districts to discuss the issue. Your help as an individual NDMA member is needed as well. You have unique knowledge of your local healthcare landscape and the unmet needs of your community. Your experience as a physician extends across every component of the healthcare system – from outpatient, inpatient, long-term care, emergency services, behavioral health, pharmaceutical coverage, and more. Reach out to your legislators now to build relationships and educate them on how the Medicaid cuts will affect their communities. Even though the legislative assembly isn't gaveled into session right now, legislators are responsible to their constituents year-round and are actively discussing these issues. Find your legislator online at *www.legis.nd.gov.*

Reach out to your legislators now to build relationships and educate them on how the Medicaid cuts will affect their communities.

Funding a strong Medicaid program strengthens not only those in need, but the entire healthcare system. Keep our children and communities healthy. Keep Medicaid strong.

Ballot Measures Offer Solutions and Problems

Courtney M. Koebele, JD

BALLOT MEASURES

On November 8, 2016, there will be two ballot measures that will have enormous impact on North Dakota physicians. NDMA's strong public health policy guides NDMA to support raising the tobacco tax and oppose medicinal marijuana.

INCREASE IN TOBACCO TAX

Raising the tobacco tax is a proven way to prevent youth tobacco initiation, encourage a reduction of adult tobacco use, reduce health care costs, and provide an overall benefit to public health. Consequently, in 2013, the NDMA House of Delegates passed a resolution to support legislative action to raise North Dakota's cigarette tax to a minimum of $2.00 per pack and all other tobacco products by a proportional amount.

Pursuant to this direction, NDMA supported the two bills filed in the 2015 legislative session to raise the tobacco tax. Unfortunately, both of the bills failed, as the legislature is very reticent when it comes to raising any sort of tax. Therefore, since North Dakota's tobacco tax has not been raised since 1993, and legislative efforts proved unsuccessful, NDMA joined a coalition of medical professionals, veterans, and legislators to support a measure for the November 2016 ballot to raise the tobacco tax.

Tobacco tax increases are proven to be one of the most effective policies to prevent youth from ever starting tobacco use. This measure is estimated to decrease youth initiation rates by 20% and prevent 5,800 North Dakota youth under the age of 18 from ever starting.

The proposed tax increases taxes from 44¢ to $2.20 a pack. This increase is estimated to bring in over $200 million in new revenue in the first biennium. The coalition is hopeful that the tax revenues decline in the second biennium as tobacco use declines.

50% of the new tax revenue will go to the veterans' tobacco tax trust fund and 50% to the Community Health Trust Fund. The Community Health Trust Fund portion is dedicated for behavioral health administered by the North Dakota Behavioral Health Planning Council (70%); counties for essential local health unit services, established by the state health council (20%); and chronic disease detection support, administered by the department of health (10%).

The impacts of the measure would be extremely beneficial to the health of all North Dakotans. Tobacco tax increases are proven to be one of the most effective policies to prevent youth from ever starting tobacco use. This measure is estimated to decrease youth initiation rates by 20% and prevent 5,800 North Dakota youth under the age of 18 from ever starting. In long-term health care costs, the state of North Dakota is estimated to save nearly $246.57 million from reductions in adult and youth tobacco use.

As North Dakota is faced with budget cuts and reduced revenues, this measure would protect and provide funding for crucial health care serves and programs for our state's veterans and North Dakotans with mental health disorders, addiction disorders, and chronic disease. The opponents of the tax argue that the retailers will suffer, however, this argument did not prove true when the smoke-free measure passed in North Dakota or when other states increased taxes on tobacco. Even with the increase, cigarettes will still be almost $1.00 cheaper in North Dakota than in Minnesota.

In the upcoming months, NDMA will support the coalition through communication with members and the community.

MEDICAL MARIJUANA

25 states have legalized medical marijuana, despite the fact that marijuana is illegal on the federal level. The proposal before the voters in North Dakota is poorly written and will be extremely difficult to implement, monitor, and administer. The measure creates an Act providing for the medical use of marijuana by registered qualified patients for defined debilitating medical conditions through registered designated caregivers and compassion centers or by growing their own marijuana. Approved medical conditions contained in the petition are: cancer and its treatments; positive status for human immunodeficiency virus (HIV); Acquired Immune Deficiency Syndrome (AIDS); decompensated cirrhosis (Hepatitis C); Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease); Post-Traumatic Stress Disorder (PTSD); agitation of Alzheimer's disease, dementia, or the treatment of these conditions; Crohn's disease or Fibromyalgia; spinal stenosis or chronic back pain including neuropathy or damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity; glaucoma; epilepsy; and other chronic diseases that produce cachexia or wasting syndrome, such as Multiple Sclerosis (MS).

A qualified patient who does not grow their own could be dispensed up to three ounces of usable marijuana. Qualified patients and designated caregivers are allowed to have up to eight marijuana plants and compassion centers are allowed 1,000 plants. The Act would create procedures for monitoring, inventorying, dispensing, cultivating, and growing marijuana, all of which would be regulated and enforced by the Department of Health. Revenue is deposited into the compassionate care fund administered by the Department of Health and is continuously appropriated. A qualified patient could be dispensed up to three ounces of usable marijuana every two weeks. To translate that amount- three ounces of marijuana equates to about 120 marijuana cigarettes!

The physician's role would be to examine the patient and execute a written certification which is a document dated and signed by a physician, stating that in the physician's opinion the patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition. Pursuant to the proposed law, a written certification shall be made only in the course of a bona fide physician-patient relationship where the qualifying patient is under the physician's care for the qualifying patient's primary care or for the qualifying patient's debilitating condition after the physician has completed an assessment of the qualifying patient's medical history and current medical condition. The bona fide physician-patient relationship may not be limited to authorization for the patient to use medical marijuana or consultation for that purpose.

An analysis of the proposal by NDMA physicians revealed the following issues:

- All forms of marijuana could be used for medical purposes, including smoking and vaping – while Minnesota, for example, does not allow medical marijuana to be smoked
- There is no age limit to getting a prescription for medical marijuana
- Smoking medical marijuana will not be treated like cigarette smoking, so it can be allowed in public places. Conceivably, a child with a prescription could bring medical marijuana to and smoke it in school
- There are no provisions for educating the public about medical marijuana and providing treatment for those who may abuse medical marijuana
- The act would become law in 30 days after being approved by voters – which is not enough time to set up a good system or hire the 32 new employees
- May put liability on the designated or primary caregiver for the safety of the patients they manage
- Requires that compassion centers be not-for-profit as determined by the Department of Health, but allows compassion centers to have investors.

The other major problem with the proposal is that the charges contained in the petition do not cover the cost to administer the program. The Department of Health estimates that the cost to administer the medical marijuana program for the first biennium is $8.7 million with an additional 32

The Department of Health estimates that the cost to administer the medical marijuana program for the first biennium is $8.7 million with an additional 32 full time employees; this includes ongoing costs of $7.3 million and one-time costs of $1.4 million.

full time employees; this includes ongoing costs of $7.3 million and one-time costs of $1.4 million. The ongoing costs of $7.3 million include overall program administration; the registration process; enforcement, onsite review and random inspection of qualified caregivers/qualified patients; and fiscal and program compliance, enforcement, onsite reviews, and random inspections for two compassion centers. The one-time costs of $1.4 million include office equipment, office space remodel/security and an electronic registration system. These costs assume only two compassion centers in the state. The incremental net costs for two additional compassion centers is $1.2 million and 3 more employees.

The measure does not take into consideration the health and safety of users, which include children, who will be exposed to the active ingredients of marijuana as it does not address safety packaging, dosage determinations, interactions with other drugs, or any other considerations that would be addressed by Federal Drug Administration (FDA) procedures were this any other drug.

Proponents of medical marijuana do not acknowledge that drugs containing the active ingredients of marijuana already exist and can be prescribed by a health care provider. Additionally, because of the push for legalization, marijuana testing is occurring and will yield scientific results in the near future. The scientific results will help guide the appropriate medical uses of marijuana. Cannabidiol, the chemical without psychoactive properties, is showing promising results as an antiseizure drug and will likely be FDA-approved and on the market in the United States in 2017. Sativex ®, a drug containing both THC and cannabidiol, is in the last stage of FDA clinical trials for Multiple Sclerosis spasticity and will also likely be FDA-approved soon. These drugs show incredible promise for the treatment of patients and will eventually be available in a tested and known quantity. In the alternative, with marijuana's plant form, a user does not know the quantity or proportion of active ingredients they are ingesting. Therefore, once the ingredients are available in pharmaceutical form, doses will be standardized and patients will know how much of which ingredients they are ingesting.

Based on the above reasons, NDMA cannot support medical marijuana. NDMA opposed medical marijuana in the 2015 legislative session and our opposition continues today. The proposed petition would be very difficult to implement in a safe and effective manner. Furthermore, medical marijuana has not been tested or vetted through the FDA's protocols; all other pharmaceuticals are required to pass this process before consumption. Therefore, dosage, side effects, and contraindications of medical marijuana are not fully known. As an organization that holds researched and clinically proven science that bolsters the health and wellness of all people in high regard, the North Dakota Medical Association cannot endorse medical marijuana.

Transitions

News from the Dean of the UND SMHS

Joshua Wynne, MD, MBA, MPH
UND Vice President for Health Affairs
Dean UND School of Medicine
and Health Sciences

This summer is a time of transition for the UND School of Medicine and Health Sciences—transition to the new academic year with the graduation of senior students and the welcoming of new students; the transition of UND's presidency from Ed Schafer to Mark Kennedy; the effect of a new budget reality for the state, UND, and the SMHS; and the move into the beautiful new home for the School of Medicine and Health Sciences.

And while the budget challenges that I discussed in my last column may well be the most important factor facing us in the long term, the recent graduation this past May of some of our finest is by far the most gratifying and noteworthy issue in the short term. One of the highlights of commencement weekend was at graduation, where Dr. Pat Carr, who was selected by the senior class to be their commencement speaker, presented a memorable address "Everything You Need to Know You Learned in Anatomy."

Another highlight at commencement was when the School and I were able to recognize the outstanding volunteer faculty from across the state who make North Dakota's community-based School of Medicine and Health Sciences as successful as it is. I was honored to bestow the Dean's Special Faculty Recognition Awards on 11 outstanding clinical faculty members who were cited by the medical students and campus deans for their outstanding contributions to our educational efforts. Many thanks to all of you who give so generously of your time and expertise!

Just a brief word about incoming President Mark Kennedy's plans for his first 180 days here at UND. Following his arrival on July 1, President Kennedy is spending his first 90 days on a listening tour—both within UND, in the local community, and across the state. He is meeting with each unit, and we had the opportunity to welcome him to the new building in Grand Forks on July 13. In addition to a briefing by the SMHS's leadership team and a videoconference with representatives from each regional campus, Mark also participated in an open forum with faculty, staff, and students. I'm sure he had a much better understanding of the School and its purpose at the end of the half-day visit. Following his listening tour, President Kennedy plans to oversee a strategic planning process for UND in anticipation of the next legislative session that begins in January 2017.

And speaking of the Legislature and planning our budget submission, we need to accept the transition to a new financial reality. We've reduced our planned expenditures for the remainder of the current biennium by 4.05 percent. About half of the reduction came from delaying the start of several programs that have not yet been implemented (most notably, the planned new family medicine residency program in Fargo). Another roughly 20 percent came from additional operational efficiencies. Only about a third of our allotment amount came from personnel adjustments, and all of those came from voluntary faculty and staff separations or by leaving vacant positions open.

We (along with the rest of higher education and other state-funded agencies) will need to prepare a 90-percent-of-base-funding budget for the next biennium (July 1, 2017–June 30, 2019). We are busy planning that budget, but it is clear that we need to accept the certainty of a new financial reality for the foreseeable future.

As we consider our budget, though, rest assured that we will resist the temptation to raise tuition to generate the needed funds because this would put an additional financial burden on the backs of our medical students who cumulatively already have substantial debt. We've worked hard to keep their costs down and will continue to do so. We've also worked hard to increase scholarship support. As a consequence, we've managed to reduce student cumulative debt. The most recent information we have from the Association of American Medical Colleges that compares the SMHS's costs and student debt load with all the other medical schools in the country (some 144 of them) shows the good news that we've been able to reduce student debt more than almost

As we consider our budget, though, rest assured that we will resist the temptation to raise tuition to generate the needed funds because this would put an additional financial burden on the backs of our medical students who cumulatively already have substantial debt.

any other medical school in the country while keeping costs low. Our students have benefited from a nearly 3 percent annual decrease in debt compared with an average annual increase of over 2 percent elsewhere, for a difference of about 5 percent per year over the past five years. One of the main reasons for this is that we specified that mitigation of student debt was our primary philanthropic focus several years ago; as a consequence, we've been able to increase giving for scholarships thanks to contributions from you and other generous donors, and the debt situation of UND's medical (and other) students has continued to brighten.

The cost for a medical student to attend the SMHS is lower than that at about 85 percent of other schools. In fact, we've been able to slightly decrease the overall cost to attend our school over the past five years, compared with a nearly 3 percent annual increase at other public medical schools.

In addition to increasing scholarships to reduce student debt, we've also worked hard to keep our costs down. Compared with all other medical schools, the cost for a medical student to attend the SMHS is lower than that at about 85 percent of other schools. In fact, we've been able to slightly decrease the overall cost to attend our school over the past five years, compared with a nearly 3 percent annual increase at other public medical schools. Good news indeed!

The move of faculty, staff, and equipment from the old building into the new facility is about 85 percent completed, and will be done in time to welcome the students back to campus later this summer. The building—a 325,000-square-foot state-of-the-art facility—has been completed on time and on budget. That's quite an accomplishment for the largest public-funded construction project in the history of the state! Credit for this noteworthy accomplishment—on time and on budget—goes to many, but primarily to our own Randy Eken, associate dean for administration and finance and chair of our Building Committee; Jim Galloway of JLG Architects; UND Vice President for Finance and Administration Alice Brekke and her team; and especially the folks at PCL Construction, our construction manager at risk. Thanks to all, particularly the many construction workers and contractors who worked on the building and compiled the amazing safety record of over 500,000 worker hours on site without a single lost day from an on-site injury!

And please remember to mark your calendar for the grand opening of the new building, which will be on Friday, October 14, as UND Homecoming 2016 wraps up. We will start the day with a CME program on sports injuries followed by the ribbon-cutting ceremony at 1:00 p.m. Then we will have tours of the building, followed by a gala dinner celebration that evening. If you haven't received an invitation in the mail or by e-mail, please RSVP to *www.med.UND.edu/events/homecoming-2016 or kristen.peterson@med.und.edu.*

Mark your calendar for the grand opening of the new building, which will be on Friday, October 14.

So the School is transitioning on multiple fronts. And while the budget challenges are real, the School is well positioned to deal with them while continuing to deliver outstanding education, scholarship and research, and service as it has done since its founding in 1905.

North Dakota Medical Association
2016 Annual Meeting
October 6-7, 2016

Hilton Garden Inn • Fargo, ND • 4351 17th Avenue South

THURSDAY, OCTOBER 6

3:00 p.m. **Council Meeting**
(council members only)

5:30 p.m. **NDMA PAC Fundraiser**
Social at Würst Bier Hall
630 1st Avenue North, Fargo

FRIDAY, OCTOBER 7

7:30 a.m. **Breakfast with the Dean**
Joshua Wynne, MD, MBA, MPH
UND SMHS

8:15 a.m. **AMA Update**
Richard Deem, Senior Vice President
American Medical Association
Advocacy Group

9:15 a.m. **House of Delegates First Session**
Reference Committee of the Whole to Follow

10:30 a.m. **Physician Burnout**
Julie Rickert, Psy.D., Associate Director
UND Center for Family Medicine, Minot

11:30 a.m. **Opioid Panel**
Mark Hardy, ND Board of Pharmacy
Duane Houdek, ND Board of Medicine
Steve Gilpin, ND Bureau of Criminal Investigation
Manuel Colon-DeJesus, MD, Pain Management Specialist

12:30 p.m. **Annual Awards Lunch**

1:15 p.m. **Candidate Forum**

2:30 p.m. **House of Delegates Final Session**
Joshua Ranum, MD, Speaker of the House

House of Delegates

As NDMA's policy-making authority, the House of Delegates (HoD) considers resolutions and reports on topics of importance to physicians and patients. Elections will be held for NDMA President, Vice President, Secretary-Treasurer, and Speaker of the House.

Delegates are elected by the district medical societies. Delegates consider and vote on resolutions, which are the foundation for NDMA policy and legislative efforts. All NDMA members may attend HoD meetings and introduce resolutions. To introduce a resolution or for assistance in drafting one, contact the NDMA office at 701-223-9475.

Breakfast with the Dean

UND SMHS - Serving North Dakota Today and Tomorrow

Dean Joshua Wynne

Joshua Wynne, MD, MBA, MPH, is the University of North Dakota's vice president for health affairs and dean of the UND School of Medicine and Health Sciences. Wynne joined the UND SMHS in 2004 and assumed his current leadership role in 2010. Under his direction, the school has intensified its focus on meeting the health care workforce needs of North Dakota.

Dr. Wynne will provide an overview of the changes happening at the school, including the new building, the expanded class sizes, and plans for the future, including the need for the continuing support of NDMA and its member physicians.

AMA Update

Richard Deem

Richard Deem is the senior vice president of the American Medical Association (AMA) Advocacy Group. In this capacity, he directs the AMA's federal, state, and private sector advocacy efforts, as well as the organization's health policy functions. The AMA's advocacy team includes a political staff that manages physician grassroots activists and a network of patient-activists that total more than 1.2 million voters and they also serve AMPAC, the AMA's political action committee, which is rated as one of the most effective political action committees in the country. Mr. Deem has served in numerous capacities in his 33-year career at the AMA. Prior to joining AMA, he served as a special assistant to former Health and Human Services Secretary Richard S. Schweiker and worked in Secretary Schweiker's Senate office for five years.

Education Sessions

Physician Burnout

Julie Rickert, PsyD

Julie Rickert, PsyD, a clinical psychologist, is an Associate Professor at the University of North Dakota School of Medicine and Health Sciences. She has served as an Associate Director at UND's family medicine residency program in Minot since 2003 where she is responsible for the behavioral health and physician well-being curriculum. She has been an active member of the Society for Teachers of Family Medicine, serving as co-chair for the Group on Family and Behavioral Health and on the steering committee of the Behavioral Science Family Systems Educator Fellowship.

Julie's presentation will identify risks of physicians neglecting their own well-being and provide cognitive strategies to motivate and engage in appropriate self-care. She will provide evidence-based strategies to effectively reduce stress, promote health, find meaning in the work physicians do, and navigate the intense interpersonal stresses involved in medicine. Julie's presentation will provide personalized benefits and strategies for improving physician health and welfare.

Opioid Panel

Mark Hardy, Pharm D, executive director, North Dakota Board of Pharmacy

Duane Houdek, JD, executive secretary, North Dakota Board of Medicine

Steve Gilpin, Special Agent, ND Bureau of Criminal Investigation

Manuel Colon, MD, MBA, CPE - Chair, Department of Pain Management, Sanford Health, Fargo

Steve Gilpin, special agent with the North Dakota Bureau of Criminal Investigation, will discuss the array of opioid abuse in the state and how Law enforcement is responding. Mark Hardy, executive director, North Dakota Board of Pharmacy will provide practical knowledge of the PDMP capabilities. Duane Houdek, executive secretary of the North Dakota Board of Medicine will describe the new Board of Medicine's administrative rules regarding the PDMP, and Manuel Colon, MD, Chair of the Department of Pain Management at Sanford Health in Fargo will provide a pain management physician's perspective on the increase in opioid cases.

NDMA Officer Elections

NDMA members nominated for 2016-2017 officer positions are listed below.
Candidates may be nominated from the floor during the morning House of Delegates session.

PRESIDENT
Debra A. Geier, MD, Jamestown, ND
Nominated by 7th District Medical Society

VICE PRESIDENT
Fadel E. Nammour, MD, Fargo, ND
Nominated by 1st District Medical Society

SECRETARY-TREASURER
Misty K. Anderson, DO, Valley City, ND
Nominated by 5th District Medical Society

SPEAKER OF THE HOUSE
Joshua C. Ranum, MD, Hettinger, ND
Nominated by 11th District Medical Society

Join us for a CANDIDATE FORUM

Candidates for key statewide offices will discuss the issues shaping their campaigns and the 2016 elections. Invited candidates include:

NORTH DAKOTA Gubernatorial Candidates

Doug Burgum

Marvin Nelson

NORTH DAKOTA U.S. Senate Candidates

Senator John Hoeven

Eliot Glassheim

NORTH DAKOTA U.S. House Candidates

Representative Kevin Kramer

Chase Iron Eyes

Annual Awards Lunch

The 2016 annual meeting luncheon and awards presentation will feature recognition of exceptional service in medicine, including the NDMA Physician Community and Professional Services Award and the Friend of Medicine Award. We will also recognize physicians who have served within the field of medicine for forty years.

NDMA PAC Fundraiser - Social

Plan to attend the NDMA PAC fundraiser social at the Würst Bier Hall (630 1st Avenue North, Fargo) featuring an assortment of German-style food and beer. Come and enjoy the company of your colleagues and enjoy the best of the Würst!

The NDMA PAC needs your support to protect quality healthcare in the practice of medicine in North Dakota. The 2016 election is right around the corner with new representation in all arenas and crucial issues at stake; therefore, it is vital that we have the necessary funding and support from you, our North Dakota physicians. Please show your support by contributing to the PAC and attending the Thursday evening fundraiser. Even if you are not able to attend, please contribute to the PAC today (see registration form).

Continuing Medical Education

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Minnesota Medical Association through the joint sponsorship of Trinity Health and the North Dakota Medical Association. Trinity Health is accredited by the Minnesota Medical Association to sponsor continuing medical education for physicians.

Trinity Health designates this live activity for a maximum of *3 AMA PRA Category 1 Credit(s)TM*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Minnesota Medical Association

Trinity Health

Lodging

Hilton Garden Inn, Fargo, ND
A block of rooms is reserved at the Hilton Garden Inn, Fargo. The group rate of $139 is available through September 15, 2016. Contact the Hilton Garden Inn at (701) 499-6000 and indicate you are with the NDMA Annual Meeting to receive this special rate. The Hilton Garden Inn is located at 4351 17th Avenue South, Fargo, North Dakota.

Cancellation Policy

No refunds will be made after September 30, 2016.

North Dakota Medical Association Annual Meeting Registration Form

October 6-7, 2016 • Hilton Garden Inn • Fargo, ND • 4351 17th Avenue South

First Name _____ MI _____ Last Name _____

Organization _____

Mailing Address _____

City _____ State _____ ZIP _____

Telephone _____ Fax _____ E-mail _____

Guest(s) First/Last Name _____

There is a $25 registration fee which includes breakfast, CME, and lunch. Please indicate below which events you will be attending. If you choose to participate in only the House of Delegates session(s), there is no registration fee.

_____ **Number attending Thursday evening NDMA PAC fundraiser social**
_____ **Number attending the Friday breakfast**
_____ **Number attending Friday educational program**
_____ **Number attending Friday luncheon**
_____ **I will ONLY attend the House of Delegates meetings**

I wish to contribute to the NDMA PAC
(Suggested donation $200) **$ _____**

_____ **Number attending annual meeting @ $25 per person** **$ _____**

NDMA non-member CME registration fee: $100 per person **$ _____**

Total amount enclosed **$ _____**

Please mail this form along with payment before September 28, 2016, to:

NDMA
1622 E Interstate Ave
Bismarck, ND 58503-0512

REGISTER ONLINE!
http://ndmed.org

Fax credit card orders to 701-223-9476
❒MasterCard ❒Visa ❒American Express

Name on credit card (please print) _____

Card Number __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ CSC _____
3 digit code on back of card
(Am. Express 4 digits on front of card)

Exp. Date __ __/__ __ Phone _____

_____ _____
Signature ZIP Code *(as it appears on your statement)*

National Issues

A Report from our AMA Delegate

AMA AMERICAN MEDICAL ASSOCIATION

Alternate Delegate A. Michael Booth, executive director Courtney Koebele, and I joined physicians from around the country in Chicago to attend the 2016 AMA Annual Meeting. The seven-day conference featured more than 170 resolutions that were discussed and voted upon as well as 36 AMA council reports and 28 reports from the AMA Board of Trustees.

A number of important headlines came out of the meeting, including the first comprehensive update of the AMA Code of Medical Ethics in more than 50 years, a keynote address from Acting Administrator of the Centers for Medicare & Medicaid Services (CMS) Andy Slavitt. He discussed the importance of physicians in guiding the Medicare payment system in the Medicare Access and CHIP Reauthorization Act (MACRA) and adopting policy calling for background checks and a waiting period for all firearms purchasers, which expanded on previous policy of requiring the same for only handguns. Eighteen states have background check requirements but the provisions vary widely. The AMA considers firearms a public health issue. The newest policy builds on numerous AMA policies that support increased firearm safety to reduce and prevent firearm violence. The new AMA policy parallels policies endorsed by other health organizations. Additionally, the AMA resolved to lobby Congress to overturn legislation that for 20 years has prevented the Centers for Disease Control and Prevention (CDC) from researching gun violence.

Shari Orser, MD

Shari Orser, MD and H. Thomas Hermann, Jr., MD, SDMA President

Above, A. Michael Booth, MD and Shari Orser, MD
Left, Courtney Koebele and Shari Orser, MD

Here is an overview of other policies adopted at the meeting:

Telemedicine

With the increasing use of telemedicine and telehealth technologies, delegates adopted new policy that outlines ethical ground rules for physicians using these technologies to treat patients. The policy, based on a report from the AMA Council on Ethical and Judicial Affairs, notes that while physicians' fundamental ethical responsibilities do not change when providing telemedicine, new technology has given rise to the need for further guidance.

According to the new policy, any physician engaging in telemedicine must disclose any financial or other interests in particular telemedicine applications or services and protect patient privacy and confidentiality. The policy outlines guidelines for physicians who either respond to individual health queries electronically or provide clinical services through telemedicine. Broadly, some of these guidelines include:

- Informing patients about the limitations of the relationship and services provided
- Encouraging telemedicine patients who have a primary care physician to inform them about their online health consultation and ensure the information from the encounter can be accessed for future episodes of care

- Recognizing the limitations of technology and taking appropriate steps to overcome them, such as by having another health care professional at the patient's location conduct an exam or obtaining vital information through remote technologies
- Ensuring patients have a basic understanding of how telemedicine technologies are used in their care, the limitations of the technologies and ways the information will be used after the patient encounter

The AMA policy requires physicians who deliver telemedicine services to be licensed in the state where the patient receives services and the delivery of care must be consistent with state's scope-of-practice laws.

Physicians voted two years ago to adopt policy governing the appropriate use of telemedicine. Most importantly, a valid physician-patient relationship must exist before telemedicine services are provided. This relationship can be established in a few different ways:

- A face-to-face examination—an exam using two-way, real-time audio and visual capabilities, like a videoconference—if a face-to-face encounter would be required for the same service in person
- A consultation with another physician who has an ongoing relationship with the patient
- Meeting evidence-based telemedicine practice guidelines developed by major medical specialty societies for establishing a patient-physician relationship

Once that relationship is established, physicians can use telemedicine technologies with their patients at their discretion.

The AMA policy requires physicians who deliver telemedicine services to be licensed in the state where the patient receives services and the delivery of care must be consistent with state's scope-of-practice laws.

Naloxone Support

Delegates at the 2016 AMA Annual Meeting adopted policy to:

- Support legislative and regulatory efforts that increase access to naloxone, including collaborative practice agreements with pharmacists and standing orders for pharmacies as well as community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route or administration for naloxone delivery
- Support efforts that enable law enforcement agencies to carry and administer naloxone
- Encourage physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients
- Encourage private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing
- Support liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense, or administer naloxone pursuant to state law
- Support efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively

Protection of Healthcare Workers from Violence

Between 2011 and 2013, about 70 percent of reported workplace assaults took place in healthcare and social service settings, according to the United States Bureau of Labor Statistics. As a result, the AMA adopted a policy that increases healthcare worker safety. The policy asks the Occupational Safety and Health Administration (OSHA) to require healthcare employers to establish violence prevention programs. OSHA currently has guidelines to increase healthcare worker safety, but they are not enforceable or required. The new policy would make OSHA guidelines a requirement and encourage physicians to undergo training that will help them prevent and respond to workplace violence threats, report incidents, and promote safe workplace culture.

Public Health Issues

Physicians adopted policies that will help improve consumer safety and reduce harm—they range from protecting children's eyes through air gun safety to supporting paid sick leave.

Medication disposal programs could help prevent overdose, improve health

An unprecedented drug overdose epidemic in the United State could be addressed in part by stronger medication return programs that treat unused medications as hazardous waste. The AMA called for support of medication return programs, funded by pharmaceutical manufacturers, and called for federal laws that encourage medication recycling and disposal.

Estimates indicate that 30-80 percent of patients do not finish prescriptions for common medications, including

Estimates indicate that 30-80 percent of patients do not finish prescriptions for common medications, including pain medications, and many patients discard these drugs at home.

pain medications, and many patients discard these drugs at home. The United States Geological Survey sampled rivers and streams and found that up to 80 percent showed traces of drugs, hormones, steroids, and personal care products.

Protecting children's eyes through air gun safety

In response to soaring rates of eye injuries among minors as a result of air guns, delegates adopted policy to better protect children and teenagers from injuries that can inflict lasting damages, despite treatment.

The new policy directs the AMA to encourage the use and provision of protective eyewear when using air guns as well as education on the proper use of protective eyewear to avoid ocular injuries.

The importance of radon testing in rentals

The AMA adopted policy that calls for renters to have similar protections as home buyers in terms testing for radon. Radon, a radioactive gas and known carcinogen, is the second leading cause of lung cancer and causes more than 20,000 deaths a year.

Only two states mandate that new renters be informed of whether a radon test has been performed and the nature of its results. The new AMA policy calls for transparency and disclosure of prior radon tests and the most recent results of tests for renters entering into a lease.

Dangers of detergent packets

Recognizing that concentrated detergent packets can compromise children's health and safety, the AMA today adopted policy calling for the redesign of detergent product packages to make them less attractive to children to help prevent accidental exposure or ingestion.

According to a study published in the Journal of the American Academy of Pediatrics, between 2012 and 2013 alone, more than 17,000 children under the age of six were exposed to highly-concentrated laundry detergent pods—resulting in hundreds of hospitalizations from ingestion and one confirmed death.

Supporting a ban on powdered alcohol

With concerns mounting from physicians and public health advocates about the health dangers associated with powdered alcohol, the AMA adopted policy supporting federal and state laws banning this substance.

Excessive alcohol use is the fourth leading preventable cause of death in the United States. Alcohol is responsible for the deaths of 4,300 youths each year and current AMA policy supports efforts to reduce youth access and consumption. Powdered alcohol, which can be mixed with liquid, poses a particular hazard to youths.

The AMA is a long-time advocate for reducing youth access to alcohol and is a strong supporter of banning the marketing of alcohol products that appeal to people under the age of 21.

Between 2012 and 2013 alone, more than 17,000 children under the age of six were exposed to highly-concentrated laundry detergent pods.

Paid sick leave can lead to better health

The AMA adopted new policy recognizing the public health benefits of paid sick leave and other discretionary time off. Citing a growing body of evidence that lack of access to paid sick leave results in the spread of infectious diseases, as well as delayed screenings, diagnoses, and treatment, the new AMA policy supports paid sick leave as well as unpaid sick leave for employees to care for themselves or a family member.

Workers without paid sick days are more likely to work sick and are more likely to delay needed medical care, which can lead to prolonged illness and worsen otherwise minor health issues, according to a report of the AMA Council on Medical Service that the policy is based upon. The AMA noted that the United States is the only industrialized nation without a federal law that guarantees paid sick leave. However, the AMA also weighed the impact of sick leave on businesses finances. The AMA pledged to continue monitoring different approaches to sick leave.

Saving Lives by Disposing Drugs and Dispensing Naloxone

Mark Hardy, PharmD
Executive Director
North Dakota Board of Pharmacy

Across the nation, prescription drug abuse is continuing to expand into an epidemic and the complications involved are being reported at an alarming rate. I know your profession, along with mine, has been called upon to address concern with abuse and misuse of drugs. Along with this comes regulatory efforts to address these complications. I want to highlight a couple of the efforts which have been rolled out to our pharmacies with the hope that they will help the public. Maybe these efforts will assist you in your practice!

Drug Disposal Program Opportunity for North Dakota Licensed Pharmacies

The North Dakota Board of Pharmacy has developed a partnership with the Yellow Jug Old Drugs Program to provide an option for the safe disposal of a patient's prescription drug medications. The Board has generously decided to provide these systems and containers to any pharmacy eligible and willing to participate in the program. This will be free of charge and depending upon the impact and scope of the program, the Board hopes to continue funding for future years.

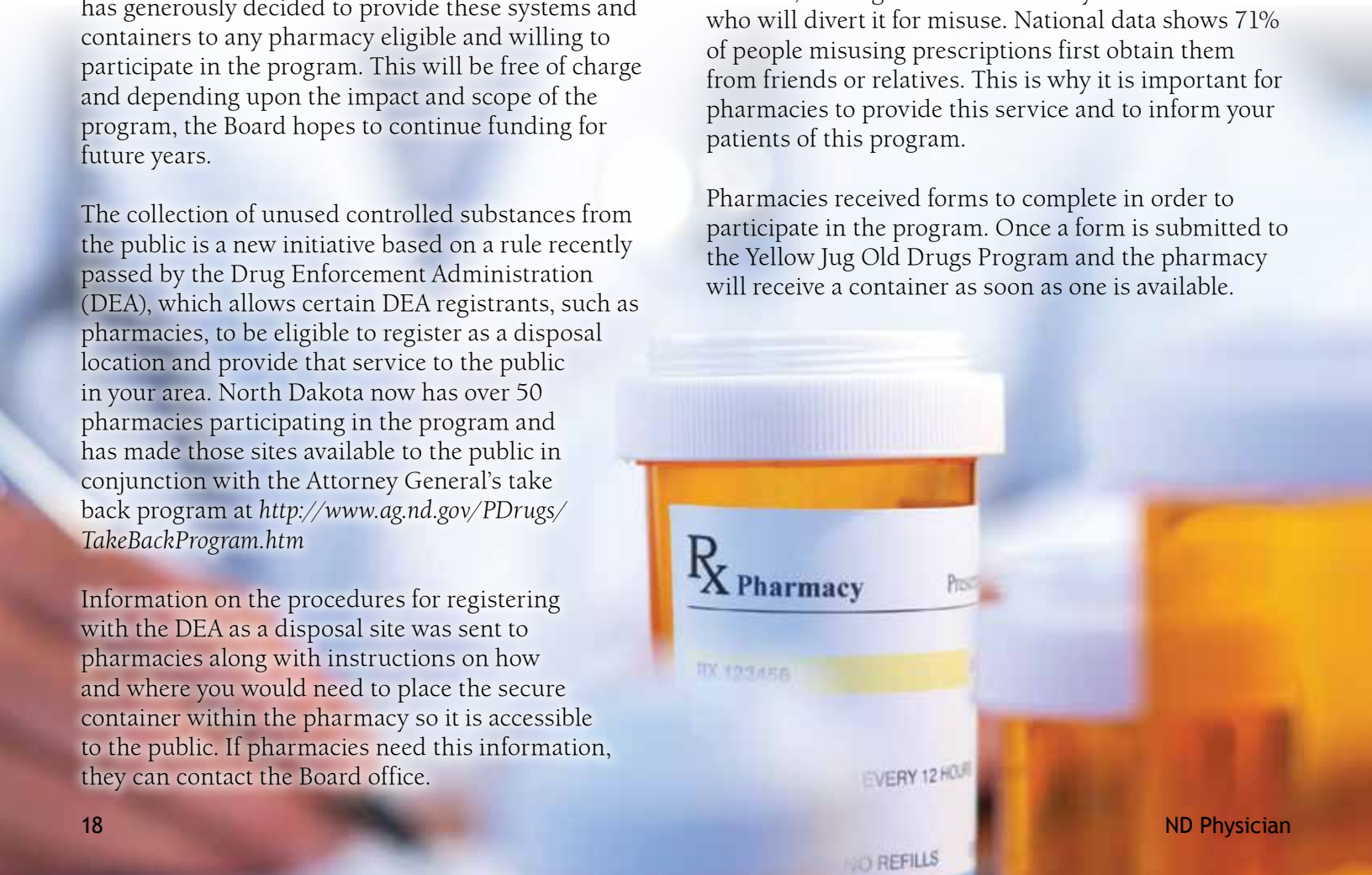
The collection of unused controlled substances from the public is a new initiative based on a rule recently passed by the Drug Enforcement Administration (DEA), which allows certain DEA registrants, such as pharmacies, to be eligible to register as a disposal location and provide that service to the public in your area. North Dakota now has over 50 pharmacies participating in the program and has made those sites available to the public in conjunction with the Attorney General's take back program at *http://www.ag.nd.gov/PDrugs/TakeBackProgram.htm*

Information on the procedures for registering with the DEA as a disposal site was sent to pharmacies along with instructions on how and where you would need to place the secure container within the pharmacy so it is accessible to the public. If pharmacies need this information, they can contact the Board office.

North Dakota now has over 50 pharmacies participating in the program and has made those sites available to the public in conjunction with the Attorney General's take back program.

The goal of providing this program to our citizens in an accessible manner is to decrease the number of prescription drug medications left in medicine cabinets, waiting to be discovered by an individual who will divert it for misuse. National data shows 71% of people misusing prescriptions first obtain them from friends or relatives. This is why it is important for pharmacies to provide this service and to inform your patients of this program.

Pharmacies received forms to complete in order to participate in the program. Once a form is submitted to the Yellow Jug Old Drugs Program and the pharmacy will receive a container as soon as one is available.



Of course, participation is voluntary and a service a pharmacy can choose to offer. We hope pharmacies will agree to provide this important service by becoming a disposal location for their patients and the public.

Limited Prescriptive Privileges for Naloxone by Pharmacists

The Board of Pharmacy finalized rules (NDAC 61-04-12) implementing the authority given by Senate Bill 2104, which granted prescriptive privileges for Naloxone to Pharmacists in North Dakota. This important measure will be one of the tools the profession of pharmacy can utilize to help save lives from the illicit and prescription drug abuse issues currently affecting so many.

The process for a pharmacist to prescribe Naloxone is available on the Board's website along with information which can be provided to at-risk patients and a patient's loved ones. The process is very straightforward and involves reviewing the context of the rule, completing one of the educational programs, and informing the Board of their intentions to prescribe this lifesaving drug. The Board will make the locations to which pharmacists are prescribing Naloxone available to the public for their information.

Included in the rule is the requirement for the pharmacist to communicate to the primary care practitioner that a prescription for Naloxone was prescribed to their patient.

Reducing Pharmaceutical Narcotics in our Communities Stakeholders Committee

The first two initiatives mentioned here, along with others, stemmed from discussions from this committee which is made up of stakeholder representing legislators, practitioners, pharmacists, treatment professionals, law enforcement, and many other groups. This group regularly meets to discuss the epidemic of the misuse of controlled substances and how we can collectively work together on initiatives to help address the issues across the state of North Dakota.

As always, the Board of Pharmacy is interested in hearing from you on solutions to help tackle the abuse trends we are seeing across the state of North Dakota. Please feel free to reach out at any time to our office.

Mohs Surgery: The Skin Cancer Treatment With the Highest Cure Rate

By Altru Health System

Truyu Aesthetic Center, a part of Altru Health System, is happy to introduce Bishr Al Dabagh, MD, FAAD, North Dakota's only fellowship trained Mohs surgeon and procedural dermatologist. Dr. Al Dabagh specializes in cutaneous oncology and reconstruction including Mohs surgery and surgical excisions of skin cancers.

There will be more than 3.5 million cases of non-melanoma skin cancers diagnosed in 2016.

Skin cancer is the most prevalent form of cancer. It is estimated that there will be more than 3.5 million cases of non-melanoma skin cancers diagnosed in 2016. Basal cell carcinoma is the most commonly diagnosed skin cancer. Basal cell carcinoma is rarely fatal or metastatic, but treatment is necessary to prevent morbidity and disfigurement. It generally occurs on sun-exposed areas and has the following features:

» Pearly or waxy appearance
» Sunken center
» Irregular blood vessels on surface
» Tendency to bleed easily after injury

Squamous cell carcinoma is the second most common skin cancer. It's rarely fatal, but may metastasize or recur if not caught early. It also commonly occurs on sun exposed areas. Characteristics include:

» Raised, dull-red skin lesion
» Thick crusted scale
» Ulcerated appearance

Melanoma is the most fatal type of skin cancer and continues to increase in incidence. It is the cause of most skin cancer deaths. Signs that a skin lesion may represent a melanoma include:

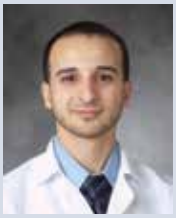
A: Asymmetry
B: Border Irregularity
C: Color (multiple colors, dark colors)
D: Diameter (larger than 6 mm)
E: Evolution (changing mole)

Also, any mole looking different than the others is worrisome.

Treatment options for skin cancer include Mohs micrographic surgery, surgical excision, and electrodessication and curettage (ED & C.) Mohs surgery is the most effective and advanced treatment for skin cancer. It offers the highest potential for cure, even if the skin cancer has been previously treated by another method. Mohs surgery is a tissue-sparing technique that employs control of 100 percent of the surgical margins. Real time evaluation of the surgical margins and precise mapping of the skin cancer allows for the highest cure rate of any treatment options available. The precise mapping of the margins also allows the surgeon to spare adjacent healthy tissue resulting in an improved cosmetic outcome and decreases the risk of defects in functionally sensitive anatomic locations. During the Mohs procedure, Dr. Al Dabagh acts as the surgeon, pathologist, and, in most cases, the reconstructive surgeon. Dr. Al Dabagh also performs surgical excisions and ED & C for less aggressive skin-primary cancers or those in less sensitive anatomic areas. The referring provider may consult with Dr. Al Dabagh on the best individualized treatment which combines the least risk and highest chance of cure for the patient.

For referrals to Dr. Al Dabagh, please contact Truyu's Aesthetic Center's surgical coordinator, Janelle, at 701-780-4278. Consults are not necessary prior to surgery and the patient will return to follow up in your practice after assessment of the healing process. Follow up documentation, including the summary of the operative note and follow up wound care, will be sent to the referring provider. Dr. Al Dabagh can also perform the initial biopsy if that is the referring provider's preference.

Dr. Bishr Al Dabagh is a board-certified dermatologist and fellowship-trained dermatologic surgeon focusing on the diagnosis and treatment of skin cancers, Mohs micrographic surgery, reconstruction, and cosmetic procedures. Patients can be assured they are provided the highest quality care given Dr. Al Dabagh's excellent eye for detail coupled with his strong clinical and academic background. Dr. Al Dabagh believes in a holistic approach to skin health and staying youthful through excellent diet, exercise, and lifestyle modifications. He is dedicated to helping patients achieve their most radiant skin from the inside out with an individualized skincare plan and total wellness program.



The Role of Physicians in Population Health

By Lisa Faust, MD, Senior Medical Director for Behavioral Health and Julie Blehm, MD, Senior Medical Director, Blue Cross Blue Shield of North Dakota

Physicians are inundated with change on many fronts as they stand at the forefront of health care transformation. Physician burnout has caught the attention of the popular media. Physician workforce shortages, early retirements, changing roles, ever-increasing administrative burdens, and difficulty recruiting to primary care are rising dilemmas for the United States' health care system. The "Quadruple Aim" is gaining attention in its attempt to emphasize inclusion of provider welfare in the pursuit of the "Triple Aim" of quality, affordability, and patient experience.

It is perhaps not surprising, then, to observe many physicians expressing skepticism about the population health management principles that underlie efforts to shift the health care system from payment-for-volume to payment-for-value. For some, it is one more source of noise in an overwhelming climate of change. In a recent survey in the New England Journal of Medicine, population health got an importance rating of 77 on a 0 (it's a fad) to 100 (it's critical for the future) scale.[1]

Health care in the United States prides itself on its great respect for patient autonomy. This has the unfortunate consequence of overconsumption of health care by some and escalating compromise of the resource for all, as evidenced by our status as 1st in the world in health care spending and 11th (and last) in industrialized nations on a broad array of outcome measures.[2]

In our conversations with physicians around the state, we hear that population health is a laudable goal, but also hear anxiety about losing focus on the "N of 1". Physicians are trained in the individual medical ethic; to prioritize

delivering the most efficacious care possible for the complexities of the patient in front of them. They tend to focus on the individual nature of health care rather than on ensuring outcomes across a population. Doctors express worry that those patients with complex co-morbidities or devastating acute conditions will get lost in the enthusiasm for population health. All are aware of the runaway inflation in health care spending, but some wonder aloud whether concerning themselves with cost and universal access to care interferes with their ability to advocate effectively for their individual patients and the "N of 1".

Our role as medical directors at Blue Cross Blue Shield of North Dakota (BCBSND) puts us at the heart of these dilemmas, and gives us a unique perspective on the conflicting imperatives of health care reform. We feel the tug of the individual medical ethic, but also the plight of the average American family of four, whose care costs in 2016 will be $25,000,[3] and that of vulnerable Americans who still fall into the gaps in access to health care.

The answers will not be easy and will require us to balance our emphasis on patient autonomy with respect for the common good. Clinical policy, reimbursement, and the culture of medicine will all have to be transformed as we get used to considering the implications of individual clinical decisions on other patients and society as a whole.

We are optimistic about the resilience of physicians and their ability to help shape the future of health care delivery. Population health can be a powerful tool in closing the evidence-based gaps in routine primary and secondary prevention. BCBSND is rolling out its Blue Alliance value-based program, which is founded on the primary care medical home, and is designed to support the journey of shifting from fee-for-service to payment for value and population-based outcomes. We are excited about the program, and at the same time we know that in our journey toward health care redesign, it cannot be the only tool. Population health will not be a panacea for all that is wrong with our health care delivery system. We must continue to wrestle with ways to execute on evidence-based care, to enhance shared decision making with patients, to integrate behavioral health services, to facilitate staff working at the top of their licenses in team-based care, and to increase asynchronous communication (telehealth, email, etc.) with patients. Additionally, we must work to decrease the administrative burdens providers are facing in their efforts to provide the highest quality care.

As physicians straddling these two worlds of provider and payer, we contemplate the worthy dilemma of balancing individual care with stewarding resource and spreading it as far as possible for the greater good. We believe that physicians do indeed have a crucial role to play in both advocating for the individual patient AND emphasizing the needs for improved community health of our North Dakota population.

1.New England Journal of Medicine Catalyst, March 31, 2016, "Care Redesign Survey: Why Population Health Management is Undervalued."
2.World Health Organization.
3. 2016 Milliman Medical Index

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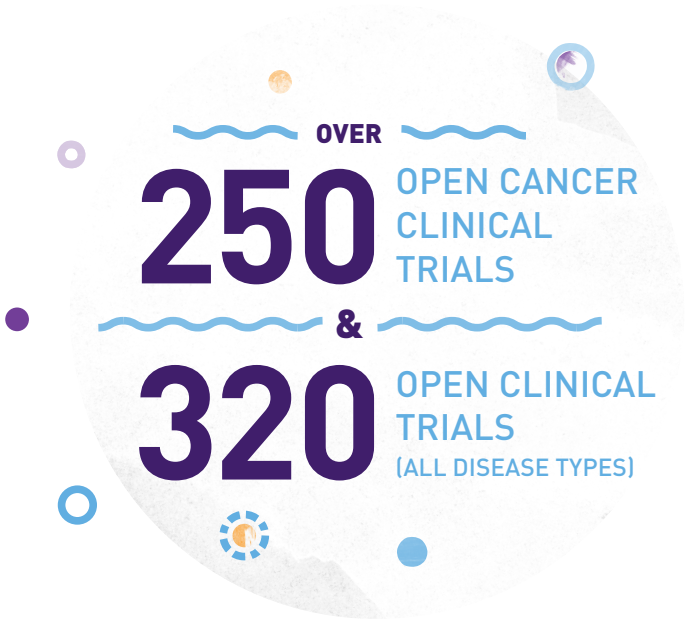
Our clinical trials.



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The types of studies conducted at Sanford Health include:

- Treatment studies to improve the standard of care.
- Prevention studies to look for better ways to prevent disease.
- Diagnostic and screening studies designed to find better ways to detect diseases.
- Quality of life studies, which explore ways to improve comfort and quality of life for patients.

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Minimizing the Risk of Opioid Overdose through Clinical Practices

Pamela Sagness
Behavioral Health Division Director

Overdose deaths in North Dakota increased from 20 deaths in 2013 to 43 deaths in 2014 (CDC/NCHS, National Vital Statistics System, Mortality). You can prevent opioid overdose through the care you take when prescribing opioid analgesics, monitoring your patient's response, and effectively identifying and addressing opioid overdose.

The risk of opioid overdose can be minimized through adherence to the following clinical practices, which are supported by a considerable body of evidence:

Assess the Patient

Obtain history of the patient's past use of drugs (illicit and prescribed medications with misuse potential) by asking specific questions that may indicate behaviors of misuse. For example, "Have you taken a medication to give you more energy or to cut down on your appetite?" and "Have you been taking anything to help you sleep (including medications or alcohol)?"

Take Precautions with New Patients

Determine who has previously cared for the patient, what medications have been prescribed and for what indications, and obtain medical records (with patient's consent). In an emergency, prescribe the smallest possible quantity, typically not exceeding a three-day supply, and arrange for a return visit the following day.

Utilize the North Dakota Prescription Drug Monitoring Program (PDMP)

Designed to monitor the prescribing and dispensing of controlled prescription drugs to patients, the PDMP can give you critical information regarding the patient's controlled substance prescription history before selecting a medication for the patient. For more information on North Dakota's PDMP, visit: *https://www.nodakpharmacy.com/pdmp-index.asp.*

Select an Appropriate Medication

Rational drug therapy demands that the efficacy and safety of all potentially useful medications be reviewed for their relevance to the patient's disease or disorder.

When an appropriate medication has been selected, the dose, schedule, and formulation should be determined. These choices often are just as important in optimizing pharmacotherapy as the choice of medication itself. Even when sound medical indications have been established, physicians typically consider three additional factors before deciding to prescribe an opioid analgesic: (1) the severity of symptoms; (2) the patient's reliability in taking medications; and (3) the dependence-producing potential of the medication.

Educate the Patient

Inform the patient about risks and benefits of the proposed therapy and ethical and legal obligations such therapy imposes on both you and the patient. Patient education should specifically address the potential for physical dependence and cognitive impairment as side effects of opioid analgesics.

Execute the Prescription Order

Careful execution of the prescription order can prevent manipulation by the patient or others intent on obtaining opioids for non-medical purposes.

Monitor Patient Response to Treatment

Proper prescription practices do not end when the patient receives a prescription. Recognizing the potential for non-adherence, especially during prolonged treatment, is a significant step in overdose prevention. If you become concerned about the behavior or clinical progress (or lack thereof) of a patient being treated with an opioid analgesic, it is advisable to seek consultation with an expert in the disorder for which the patient is being treated and an addiction expert.

The patient's obligation extends to keeping the medication in a locked cabinet or otherwise restricting access to it and to safely disposing of any unused supply. *Visit www.ag.nd.gov/PDrugs/TakeBackProgram.htm* for a local Take Back Location.

Prescribe Naloxone Along with the Patient's Initial Opioid Prescription

Prescribing naloxone is a vital link in preventing overdose deaths from opioid pain medications and heroin.

LEGAL AND LIABILITY CONSIDERATIONS

Prescribing naloxone is consistent with the drug's FDA-approved indication, resulting in no increased liability so long as the prescriber adheres to general rules of professional conduct. You are protected under North Dakota law. North Dakota offers immunity from civil and criminal liability to individuals who prescribe, distribute, dispense, receive, possess, or administer an opioid antagonist under North Dakota Century Code 23-01-42.

Naloxone competitively binds opioid receptors and is the antidote to acute opioid toxicity. With proper education, patients on long-term opioid therapy and others at risk may benefit from a naloxone prescription.

Consider prescribing intranasal spray (Narcan®) or auto-injector (Evzio®) naloxone to patients who are:

- Taking high doses of opioids for long-term pain management
- Receiving rotating opioid medication regimens (at risk for incomplete cross-tolerance)
- Using opioids for legitimate medical need, coupled with a suspected or confirmed history of substance use disorder or non-medical use of prescription or illicit opioids
- Using a combination of opioids plus a benzodiazepine or other sedative
- Combining opioids with alcohol, OTC drugs, or other central nervous system depressants
- Recently released from incarceration or an abstinent based program (and presumably with a reduced opioid tolerance and high risk of relapse)
- On certain opioid preparations that may increase risk for opioid overdose such as extended release/long-acting preparations

Most private health insurance plans, Medicare, and Medicaid cover naloxone for the treatment of opioid overdose.

Decide Whether and When to End Opioid Therapy: If out-of-control behaviors indicate that continued prescribing is unsafe or causing harm to the patient, immediate cessation of prescribing is advised. These may include altering or selling prescriptions, accidental or intentional overdose, multiple episodes or running out early, doctor shopping, or engaging in threatening behavior. When such events arise, it is important to separate the patient as a person from the behaviors caused by the disease of addiction, as by demonstrating a positive regard for the person but no tolerance for the aberrant behaviors.

Visit *www.prevention.nd.gov/stopoverdose* for more information.

Source: Substance Abuse and Mental Health Services Administration. SAMHSA Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA) 16-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016.

Reaching 80% Screened for Colorectal Cancer by 2018

A Summary of Recent Trainings in North Dakota

By Shannon Bacon, American Cancer Society and
Joyce Sayler, Community Partnership Coordinator, Division of Cancer Prevention and Control, North Dakota Department of Health

In May 2016, over 200 medical professionals across North Dakota attended in-person trainings where they learned about evidence-based systems changes for improving colorectal cancer screening rates. Dr. Durado Brooks, national Director of Cancer Control Intervention for the American Cancer Society, was the keynote speaker, and his key points are highlighted throughout this article. These trainings were part of the 80% by 2018 initiative,[1] a national movement in which over 1,000 organizations have committed to eliminating colorectal cancer as a major public health problem and are working toward the shared goal of reaching 80% screened for colorectal cancer by 2018.

Each year, approximately 400 North Dakotans will be diagnosed with colorectal cancer and 140 will die from the disease. These numbers can be significantly reduced through routine screening for age eligible individuals. Statistics from 2014 indicate that 38% of North Dakotans who are 50 through 75 years of age are either past due or have never been screened for colorectal cancer. Also of concern, is that the North Dakota Statewide Cancer Registry reports 42% of men and women from our state are diagnosed with colorectal cancer at late stage, when the disease is more difficult to treat.

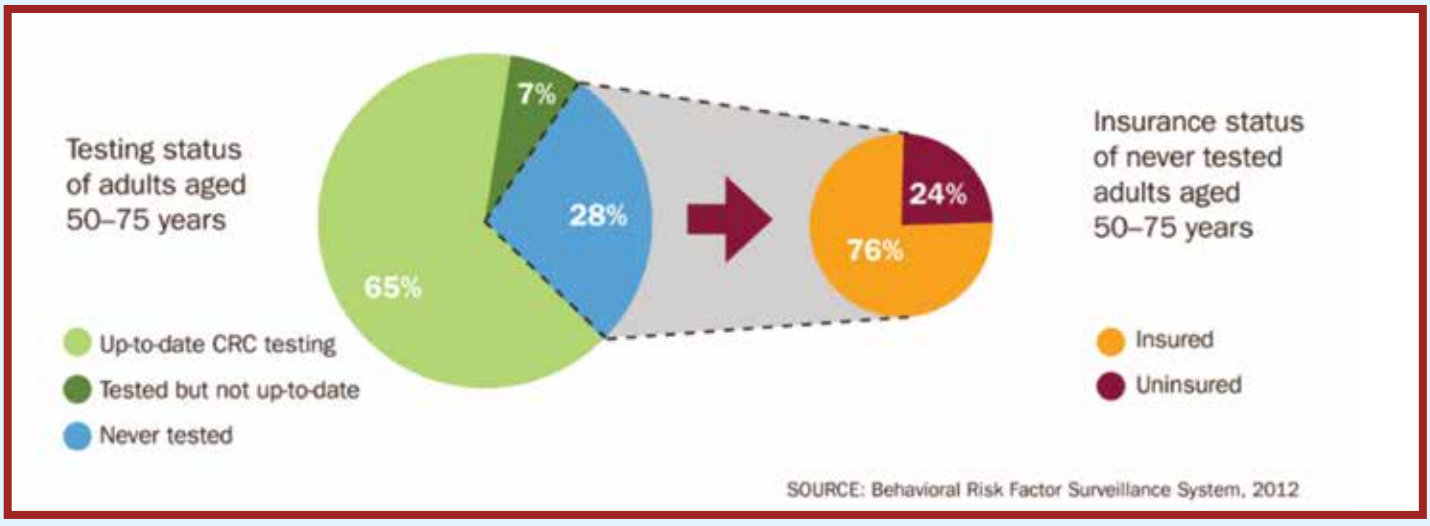
Who Is Not Getting Screened?

Nationally, 35% of individuals 50 to 75 years of age are not up to date with colorectal cancer screening. This is slightly less than the North Dakota percentage of 38%. As demonstrated in the slide below from Dr. Brooks, 76% of the unscreened population has health insurance.

Cost of screening tests is an issue for some patients, but it may not be the only barrier as evidenced by the national percentage of unscreened who are insured. Identifying a patient's barrier(s) to screening is important to ensure they are willing and able to complete screening tests. For a list of common barriers, view the National Colorectal Cancer Roundtable 80% by 2018 Communications Guidebook.[2]

Who should be screened?

Because colorectal cancer usually develops after age 50, all individuals 50 through 75 years of age should get screened. As of June 2016, the United States Preventive Task Force (USPSTF) has provided guidance for adults aged 76 to 85 years of age for colorectal cancer screening. The USPSTF guidance states that the decision to screen for colorectal cancer in adults aged 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history. Those in this age range who have never been screened for colorectal cancer are most likely to benefit. Providers will also want to consider whether a patient is healthy enough to undergo treatment if colorectal



cancer is detected and whether they have any comorbid conditions that significantly limit their life expectancy. USPSTF provides information on this recommendation change on their website.[3]

Recommended Tests & Risk Assessment

When making the decision as to what is the appropriate colorectal cancer screening test for each adult, the level of risk must be taken into consideration. Individuals of average risk can be counseled about screening options.

The American Cancer Society and the USPSTF recommend the following testing options for **average risk individuals**:

- Colonoscopy
- High sensitivity fecal occult blood test
  - Fecal immunochemical tests (FIT)
  - High Sensitivity Guaiac tests
  - FIT DNA test as of June 2016[4]

When utilizing stool-based sampling, it is important to know that digital rectal exam **(DRE) samples are not recommended**. Research has demonstrated that sampling through DRE will miss 90% of colorectal cancer cases.

If an individual is considered of **increased or high risk**, the recommended screening test is colonoscopy.
Individuals of increased and high risk fall within the following categories:

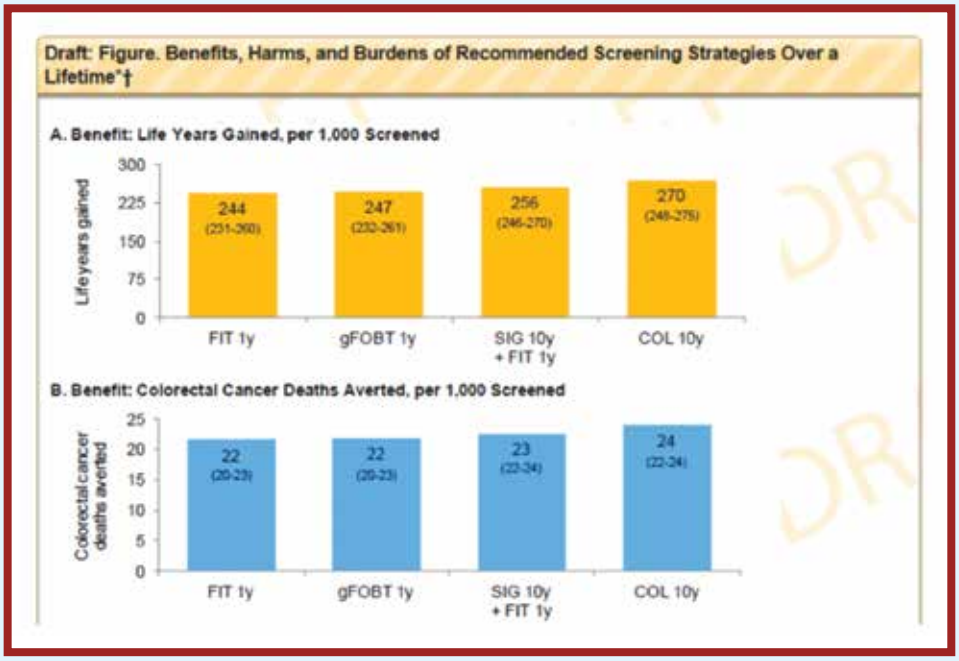
- Personal history of
  - Adenomatous Polyps
  - Colorectal cancer
  - Inflammatory bowel disease
  - Ulcerative colitis
  - Crohn's disease
- Family history
  - Colorectal cancer or adenomas
  - Hereditary syndrome (FAP, Lynch Syndrome)

The vast majority of age eligible adults for colorectal cancer screening are within the average risk category.

Is There a "Gold Standard" in Colorectal Cancer Screening?

Providers often think the gold standard for colorectal cancer screening is colonoscopy, but research has shown this may not always be true, especially for adults of average risk. While colonoscopy is an excellent test, evidence from research does not support it to be the "gold standard." Reasons for this include that colonoscopy misses 10% of significant lesions in expert settings, is costlier on a one-time basis, and has a higher percentage of injury than other colorectal cancer screening tests. Colonoscopy can also come with barriers related to access, patient preferences, and bowel prep requirements.

Interestingly, there is a wide variation in procedure quality when data regarding the test is captured and available. The American Society of Gastrointestinal Endoscopy and the American College of Gastroenterology Task Force have developed key quality indicators for endoscopy that includes prep quality, fecal intubation rate, and adenoma detection rate. There are endoscopists who are unaware of their performance on these measures, since most facilities do not track or report their data to providers. A Kaiser study regarding adenoma detection rate (ADR) and outcomes from 136 gastroenterologists over a ten-year study found the ADR ranging from 7.4 to 52.5%. According to quality indicators, endoscopists should average a rate of one adenoma found in 30% of the time in men and 20% of the time in women.



FOBT/FIT Accuracy & Advantages

There are two major types of recommended take-home stool test options for colorectal cancer screening: the FIT and the high-sensitivity FOBT. The most common type in the US is the FOBT. Newer FOBT versions (such as Hemoccult Sensa) have better sensitivity and solid evidence, while older forms (such as Hemoccult II) are not recommended for CRC screening. FOBT requires specimens from three bowel movements, and results can be influenced by foods and medications. The other form of take-home stool test is the FIT, which is specific for human blood and lower GI bleeding and results are not influenced by foods or medications. Some FIT brands require only one or two specimens, which can produce higher return rates from patients.

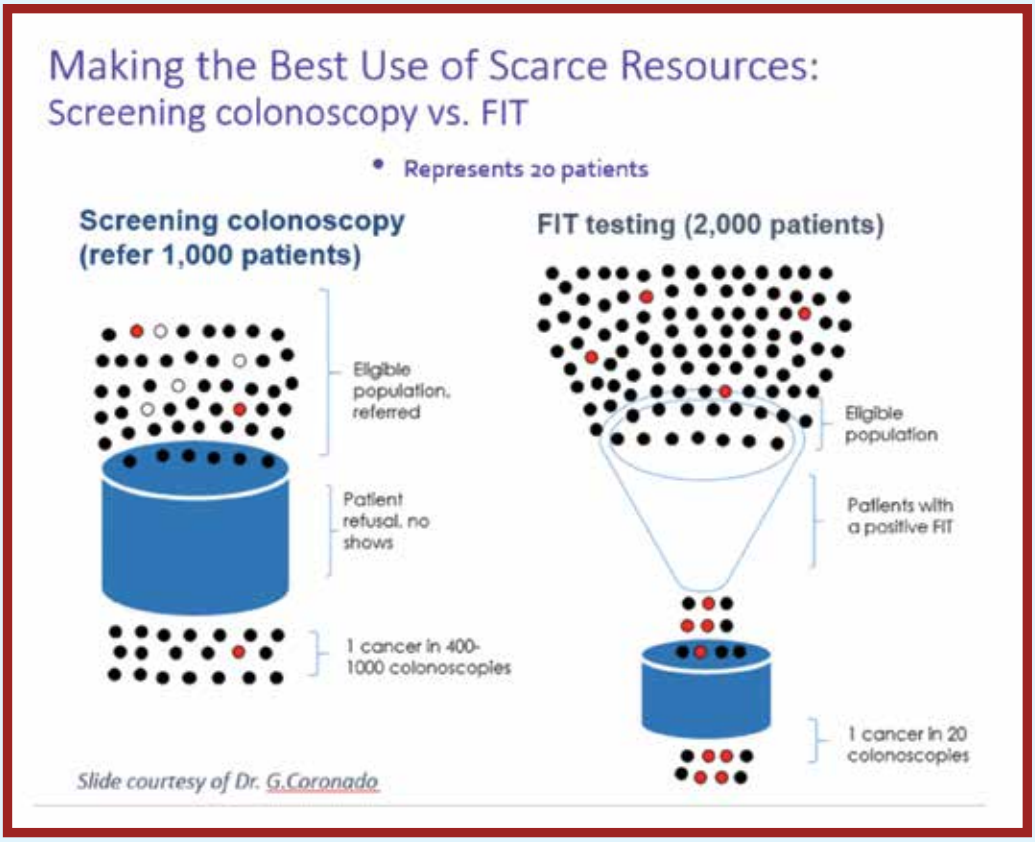
As demonstrated in the slide above from Dr. Brooks, years of life saved through annual stool-blood screening programs are comparable to a high-quality colonoscopy based program, when positive stool tests are followed by colonoscopy.
For more information on FIT accuracy, see the article Accuracy of Fecal Immunochemical Tests for Colorectal

Cancer: Systemic Review & Meta-analysis (2014)[5].

Advantages of FIT include:

- It is less expensive
- It requires no bowel preparation
- It can be done in the privacy of one's home
- It does not require time off from work or assistance getting home
- It is is non-invasive (no risk of pain, bleeding, or perforation)
- It limits the need for colonoscopies (required only if stool blood testing is abnormal)

For more information on FIT and FOBT, view the American Cancer Society & National Colorectal Cancer Roundtable's Clinicians Guide[6], which provides state-of-the-science information about FOBT and FIT test performance and characteristics of high quality screening programs.



Making the Most of Limited Resources

The ultimate goal of increasing CRC screening rates will require an options-based screening approach which includes FIT. In North Dakota, we do not have the capacity to provide colonoscopy for every age-eligible individual. The slide at top shared by Dr. Brooks demonstrates how FIT testing makes the best use of scarce resources.

Stool Test Quality Issues

It is important to be aware of potential stool test quality issues. Stool tests are appropriate only for average risk patients, and all positive tests must be followed up with colonoscopy. The patient should be aware of potential cost sharing issues related to follow-up colonoscopy if their initial screening method is a stool test.

FITs With Published Data*
Available in the US

Name	Manufacturer
Hemoccult-ICT/Flexsure OBT	Beckman-Coulter
Hemosure One Step	WHPM, Inc.
InSure / ColoVantage	Clinical Genomics
OC-Sensor / OC FIT-CHEK	Polymedco
OC-Auto Micro	Polymedco
OC-Light	Polymedco

**This list may not be comprehensive.*

Providers should be aware that **not all FITs are created equal**. The FDA clears guaiac FOBTs and FITs only for "detection of blood," but no assessment of the tests' cancer detection capabilities are required. Of the FDA-cleared FITs in the US, only about 25% have published data on their performance for detection of CRC or adenoma. Some tests are currently marketed as "single sample" tests with no performance data on this use. The FDA is reportedly updating their clearance criteria. The brands in the slide above from Dr. Brooks have published data on their performance for colorectal cancer screening.

1. http://nccrt.org/tools/80-percent-by-2018/, 2. http://nccrt.org/tools/80-percent-by-2018/80-by-2018-communications-guidebook/, 3. http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening2, 4. http://pressroom.cancer.org/uspstfcoloncancerscreeningguideline, 5. http://annals.org/article.aspx?articleid=1819122, 6. http://www.cancer.org/healthy/informationforhealthcareprofessionals/colonmdclinicansinformationsource/index, 7. http://www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-029276.pdf, 8. http://www.ndhealth.gov/compcancer/cancer-programs/80-by-2018/, 9. http://nccrt.org/tools/80-percent-by-2018/80-percent-by-2018-pledge/

Take Action

- To learn more about Evidence Based Interventions to increase cancer screening rates, view the American Cancer Society & National Colorectal Cancer Roundtable's Action Plan[7] guide

- The North Dakota Colorectal Cancer Roundtable,[8] co-lead by the American Cancer Society and the North Dakota Department of Health, is a statewide coalition of organizations dedicated to reducing the incidence of and mortality from colorectal cancer in our state, through coordinated leadership and strategic planning. The Roundtable has a number of workgroups, including FluFIT, Access to Care, Provider Education, and Public Awareness. **If you are interested in joining a workgroup or receiving email updates from the Roundtable, please contact Shannon Bacon (Shannon.bacon@cancer.org) or Joyce Sayler (jsayler@nd.gov)**

- Take the 80% by 2018 Pledge[9] with the National Colorectal Cancer Roundtable

THANK YOU

to the following organizations who supported the funding and/or planning of these trainings:

- **American Cancer Society**
- **North Dakota Department of Health**
- **Blue Cross Blue Shield of North Dakota**
- **North Dakota Medical Association**
- **Community HealthCare Association of the Dakotas**
- **Great Plains Tribal Chairmen's Health Board**
- **Sanford Health**
- **Essentia Health**
- **Altru Health**
- **CHI St. Alexius**
- **Mid-Dakota**
- **South Dakota Department of Health**
- **Trinity Health**

NORTH DAKOTA MEDICAL ASSOCIATION AWARDS

The North Dakota Medical Association is proud to sponsor awards for three outstanding sophomores and eight outstanding graduating seniors. Here is the roster of the exemplary students that received the awards this spring.

Second-year students are nominated by their peers, the Class of 2018, and recognized for outstanding performance in the following three curricular areas:

Michael Gilchrist
Bismarck, ND

Group Leadership and Professionalism—Engages in ethical conduct, facilitates group interaction and productivity, motivates others to learn, exhibits personal integrity, and interacts with others appropriately with respect and courtesy.

Katherine (Kacy) Benedict, Sabin, MN

Peer Teaching—Outstanding contributions to the group's database and facilitating group learning, skillful and accurate presentations, and willingness to assist fellow classmates to learn concepts they do not understand.

Brandon Fisher
Fargo, ND

Integration of Basic Science and Clinical Application—Ability to analyze problems, generate hypotheses, set priorities, test hypotheses and formulate alternative hypotheses, draw appropriate conclusions, and apply the knowledge to patient cases.

Class of 2016 Award Winners

The North Dakota Medical Association Awards are presented to three outstanding students in the senior class who exemplify high scholarship, integrity, leadership, and initiative.

Natalie M. Kollman
Fargo, ND

David P. Larson
Austin, MN

John C. Riedinger
Bismarck, ND

North Dakota District Medical Society Awards

These prestigious awards are given by the district medical society on each campus to the student who best exemplifies high scholarship and characteristics of integrity, leadership, and initiative.

First District, Fargo
Scott T. Allen
North Mankato, MN

Third District, Grand Forks
Michael D. Traynor, Jr.
Fargo, ND

Fourth District, Minot
Anna L. Cymbaluk, Crookston, MN

Fourth District, Minot
Shaynna M. Metzger
Dickinson, ND

Sixth District, Bismarck
Aaron A. H. Smith,
Grand Forks, ND

Congratulations to all the UND SMHS graduates and award winners!

A Win-Win-Win Measure for North Dakotans

It is not every day that the public is given the chance to enact policy that has significant and proven health and economic impacts across an entire population. For North Dakotans, that day just may come this fall.

How, you may ask? Here's how...

In March of this year, 30 North Dakotans and the Raise it for Health ND group, a coalition of dozens of organizations, announced plans to initiate a ballot measure to increase the state's dangerously low tobacco taxes and dedicate those revenues to critical programs and services for North Dakota's veterans and individuals struggling with mental illness, substance abuse, and chronic disease.

The decision to initiate this measure was not made without seeking a policy change, multiple times, through legislative action. Unfortunately, even in the face of public pressure for veterans' programs and behavioral health funding as well as public support for tobacco prevention policies, the votes came up short. The Raise it for Health ND coalition felt strongly that if our elected officials would not act, it would.

To place this initiative on the ballot, state law required the committee to submit 13,452 valid signatures by July 11. Once submitted, the North Dakota Secretary of State has 35 days to review and approve the signatures. We are proud to announce that on July 7th, after hundreds of volunteers across the state worked for months to earn the support of North Dakotans for this initiative, the Raise it for Health ND coalition submitted nearly 23,000 signatures to the Secretary of State.

Up to this point, our actions were guided by public polling and the strength of our partners in the Raise it for Health ND coalition. Thanks to the overwhelming support we received from North Dakotans during the signature collection process, however, our trust and desire to leave this decision in the hands of the voters were clearly solidified.

The benefits of this potential measure are truly immeasurable. Increasing the price of tobacco is proven to be the most effective way to prevent our young people from ever starting to smoke. The increase proposed in this measure is estimated to reduce youth initiation in North Dakota by 20%[1] and keep tobacco out of the hands of 5,800 North Dakota kids[1], giving our state the potential of reducing our youth smoking rates to the single digits. In addition, tobacco tax increases provide current adult users, more than half of whom want and have tried to quit, with the motivation they need, in a state that also provides free cessation services through NDQuits, to achieve success.

Eric L. Johnson, MD, Grand Forks physician
President of TFND, Chairman of the Raise it for Health ND sponsoring committee

Increasing the price of tobacco is proven to be the most effective way to prevent our young people from ever starting to smoke. The increase proposed in this measure is estimated to reduce youth initiation in North Dakota by 20%[1] and keep tobacco out of the hands of 5,800 North Dakota kids.

Reductions in adult and youth tobacco use also result in long-term health care cost savings (measured over the lifetimes of adults who quit and kids who never start), and in the case of this measure, North Dakota stands to save an estimated $246.57 million[1]. This is significant when everyone is interested in reducing health care costs and when the annual health care expenditures in North Dakota directly caused by tobacco use are estimated at $326 million[1].

Though the driving force behind this measure is ultimately to save lives by reducing and preventing tobacco use, our coalition is also committed to providing a solution to

Raise IT for health north dakota

This measure is estimated to generate around $200 million in new revenue. These dollars would be tied directly to funding comprehensive plans to address the continued unmet needs of our state's veterans, public health programming, and North Dakotans struggling with mental illness, substance abuse, and chronic disease.

underfunded issues when we saw no other solution in sight. At a time when our state is facing revenue shortfalls and will need to make the necessary cuts to balance budgets, tobacco tax increases, even when accounting for reduced consumption and sales, are a revenue net positive. This measure is estimated to generate around $200 million in new revenue. These dollars would be tied directly to funding comprehensive plans to address the continued unmet needs of our state's veterans, public health programming, and North Dakotans struggling with mental illness, substance abuse, and chronic disease.

What they won't tell you is that when you start from next to nothing (our current tobacco tax rates are among the lowest in the nation - at just $0.44/pack - and has not been increased since 1993), *any* increase represented as a percentage seems high.

In our opinion, this measure is a win-win-win.

But over the coming months, you will undoubtedly hear from our opposition, led and funded by the out-of-state tobacco industry and the millions of dollars they will pay to protect the profits they make on the addictive and deadly products they sell. You will hear that this "400% increase" is unprecedented and outrageous. What they won't tell you is that when you start from next to nothing (our current tobacco tax rates are among the lowest in the nation – at just $0.44/pack – and has not been increased since 1993), ***any*** increase represented as a percentage seems high.

The fact remains that the greatest health impacts are realized through significant price increases. The increase in this measure only puts North Dakota more in line with the tobacco tax rates of our neighboring states, the average of which is $2.08/pack. In fact, if this measure passes, Minnesota's cigarette tax will still be almost $1.00 higher than North Dakota's. Doesn't sound so outrageous now, does it?

In the words of the former World Health Organization Director, Harlem Brundtland, MD, MPH, "If we [do] not act decisively, a hundred years from now, our grandchildren and their children [will] look back and seriously question how people claiming to be committed to public health and social justice allowed the tobacco epidemic to unfold unchecked."

If years of data prove this policy's effectiveness, how can we honestly not act? The Raise it for Health ND coalition is committed to passing this health policy, and we are grateful for partners like the North Dakota Medical Association who have joined in that commitment.

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1. "New Revenues, Public Health Benefits and Cost Savings from a $1.75 Cigarette Tax Increase in North Dakota," Campaign for Tobacco-Free Kids & American Cancer Society Cancer Action Network. Updated January 6, 2016.

UND School of Medicine and Health Sciences Recognizes Volunteer Faculty

The University of North Dakota School of Medicine and Health Sciences presented the Dean's Special Recognition Awards for Outstanding Volunteer Faculty to the following physicians during commencement ceremonies on Sunday, May 15.

- J. David Amsbury, DO, Clinical Instructor of Obstetrics and Gynecology, Minot, ND
- Andrew R. Hetland, MD, Clinical Assistant Professor of Surgery and alumnus (MD Class of 2004), Bismarck, ND
- Michael J. Holland, MD, Clinical Professor of Pediatrics, Minot, ND
- Catherine E. Houle, MD, Clinical Assistant Professor of Family and Community Medicine, Hettinger, ND
- Ryan A. Hoovestol, MD, Clinical Assistant Professor of Internal Medicine and alumnus (MD Class of 2008), Mandan, ND
- Michelle M. Jorgensen, MD, Clinical Assistant Professor of Psychiatry and Behavioral Science, Fargo, ND
- Kenneth J. Keller, MD, Clinical Associate Professor of Radiology and alumnus (MD Class of 1979), Minot, ND
- Jennifer L. Mullally, MD, Clinical Assistant Professor of Pediatrics and alumna (MD Class of 2010), West Fargo, ND
- Joshua C. Ranum, MD, Clinical Assistant Professor of Internal Medicine and alumnus (MD Class of 2008), Hettinger, ND
- Elizabeth A. Stroup-Menge, MS, Clinical Instructor of Psychiatry and Behavioral Science, Bismarck, ND
- Marissa A. Wisdom, MD, Clinical Assistant Professor of Obstetrics and Gynecology and alumna (M.D. Class of 2005), Bismarck, ND

"As a community-based school, we could not carry out our educational mission without the dedication and sacrifice of our voluntary faculty members," said Joshua Wynne, MD, MBA, MPH, UND vice president for health affairs and dean of the School of Medicine and Health Sciences. "In large measure, the quality of our medical education program is dependent on the many physicians throughout the state who serve as volunteer faculty members. They have added and incorporated this activity into their daily medical practices and welcomed our medical students to learn from them and their patients."

"These physicians have gone above and beyond the call of duty in giving our students the benefit of their time, experience, knowledge, and wisdom gained from years of caring for patients," Wynne said. "By example, they have served as superior role models and encouraged our students to define and adopt the highest standards of medical service."

NDMA congratulates and thanks each of these outstanding faculty members for their service to the health care delivery system in North Dakota!

Wall or Window?

An electronic health record system needn't interfere with the doctor-patient relationship. It can actually improve it.

Patrice F. Hirning, MD, CPHRM
Practicing Physician, Utah Physician Advisory Council

From 2006–2013, the percentage of physicians using any electronic health record (EHR) system increased nearly threefold, from 29.2 percent to 78.4 percent. In 2013, 48.1 percent of physicians used the more comprehensive "basic" system, compared to 10.5 percent of physicians in 2006.[1] The significant increase in EHR use has been fueled by incentive payments for Meaningful Use put in place by the HITECH Act, which was part of the American Recovery and Reinvestment Act of 2009. As of June 2014, 75 percent of the nation's eligible professionals and 92 percent of eligible hospitals had received incentive payments from the EHR Incentive Programs.[2]

Though it would be ideal if the EHR improved patient care by placing all important clinical information in front of us at all times, the lack of interoperability between systems has affected health care's ability to reach that goal. Unfortunately for many practitioners, there is a feeling that the EHR is just one more burden added to patient care. So, how can we utilize the EHR (which is not going away) to improve our relationship with our patients rather than interfere with our interactions?

Set up your space

Many practitioners have added a computer, monitor, keyboard, and mouse to an exam or hospital room that was not designed for that additional equipment. This often leads to the practitioner facing a wall to input data and not looking at the patient. Eye contact with patients and family is critical to making a connection and letting them know that the practitioner cares and is listening. Using a rolling cart, laptop, or tablet can mean that the practitioner can focus on the patient during the interaction. And turning the screen so the patient can see what is being entered can help the patient feel involved; they can also assist the practitioner in not entering inaccurate information into the EHR.

Access information

There is a wealth of information available in our computers and on the Internet to assist us in engaging our patients. Practioners can review results with patients in real time to assure that accurate information is in the correct record. Reviewing results and responses to therapy assists in the diagnostic process, and utilizing clinical decision support tools will assist in diagnosis and therapy. And it is possible to use a smart phone or tablet to share more information with your patient, thus not switching between systems on a single device. It is ideal when these additional tools can be reached within the EHR in order to add extra information to the documentation of that visit.

Share information

Placing information on the portal for your EHR engages patients to look at results and reports. This can save staff time and allow information to be there for patients and families to review. However, it is very important to respond to queries from patients and also to be sure that the system is monitored in order to verify that results have been reviewed. It is imperative to contact directly those patients not using the portal, to be sure that the results have been received.

Respect your patient's values

As practitioners work to improve patient engagement in their own care, it is important to respect the patient's personal values. How much information does an individual patient want to review? Is your patient afraid that their personal data is not protected or is at risk of being seen by someone other than for whom it is intended? Is the patient concerned that he or she has only become a template in a computer program and is no longer a person to be cared for and cared about?

I personally look forward to improved care for our patients in this digital age. The switch to EHR was not easy for me after 20 years of paper charting, but now I see the improved efficiencies and the ease of access to records as a plus. I also look forward to engaging my patients in their care and sharing the diagnostic and therapeutic process with patients and families to improve the experience for all.

EHR NO-NOs

When using an EHR in front of your patient, avoid these common mistakes:

- Putting all of your attention on the computer monitor
- Not paying attention to body language (yours and the patient's)
- Blocking your view of the patient with the monitor
- Failure to confirm that the data being entered is correct
- Failure to adequately protect your patient's sensitive data
- Failure of practitioner or staff to respond to contact from patients through the portal

References
1. Centers for Disease Control. Quick Stats: Percentage of Office Based Physicians with Electronic Health Record (EHR) Systems. National Ambulatory Medical Care Survey, United States, 2006–2013, MMWR. February 7, 2014,63(05);119-119.
2. Federal Health IT Strategic Plan 2015–2020.
Prepared by the Office of the National Coordinator for Health Information Technology (ONC) Office of the Secretary, United States Department of Health and Human Services; p. 4.

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2016 Events Calendar

August 15
Opioid Symposium
Holiday Inn
Fargo, ND

August 16
Opioid Symposium
Bismarck Event Center
Bismarck, ND

August 17
Quality Health Associates of North Dakota's Annual Quality Forum
Ramkota Inn
Bismarck, ND

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

October 21
ND Chapter American College of Physicians Annual Meeting
University of North Dakota School of Medicine and Health Sciences
Grand Forks, ND

November 5
ND Psychiatric Society's Fall Meeting
Cambria Suites
Fargo, ND

November 11-12
ND Academy of Family Physicians Annual Meeting
Alerus Center
Grand Forks, ND

November 12-15
AMA Interim Meeting
Orlando, FL

November 16
e-Health Summit
Radisson Hotel
Bismarck, ND

November 18
ND Board of Medicine Meeting
Bismarck, ND

January 3, 2017
Start of the 65th Legislative Assembly
Bismarck, ND

January 16-20, 2017
ND Academy of Family Physicians Annual Big Sky Conference
Big Sky, MT

January 31, 2017
Hospital, Physician, and EMS Day at the Capitol
Bismarck, ND

If you would like more information on any of these events, please visit NDMA's website at *www.ndmed.org*