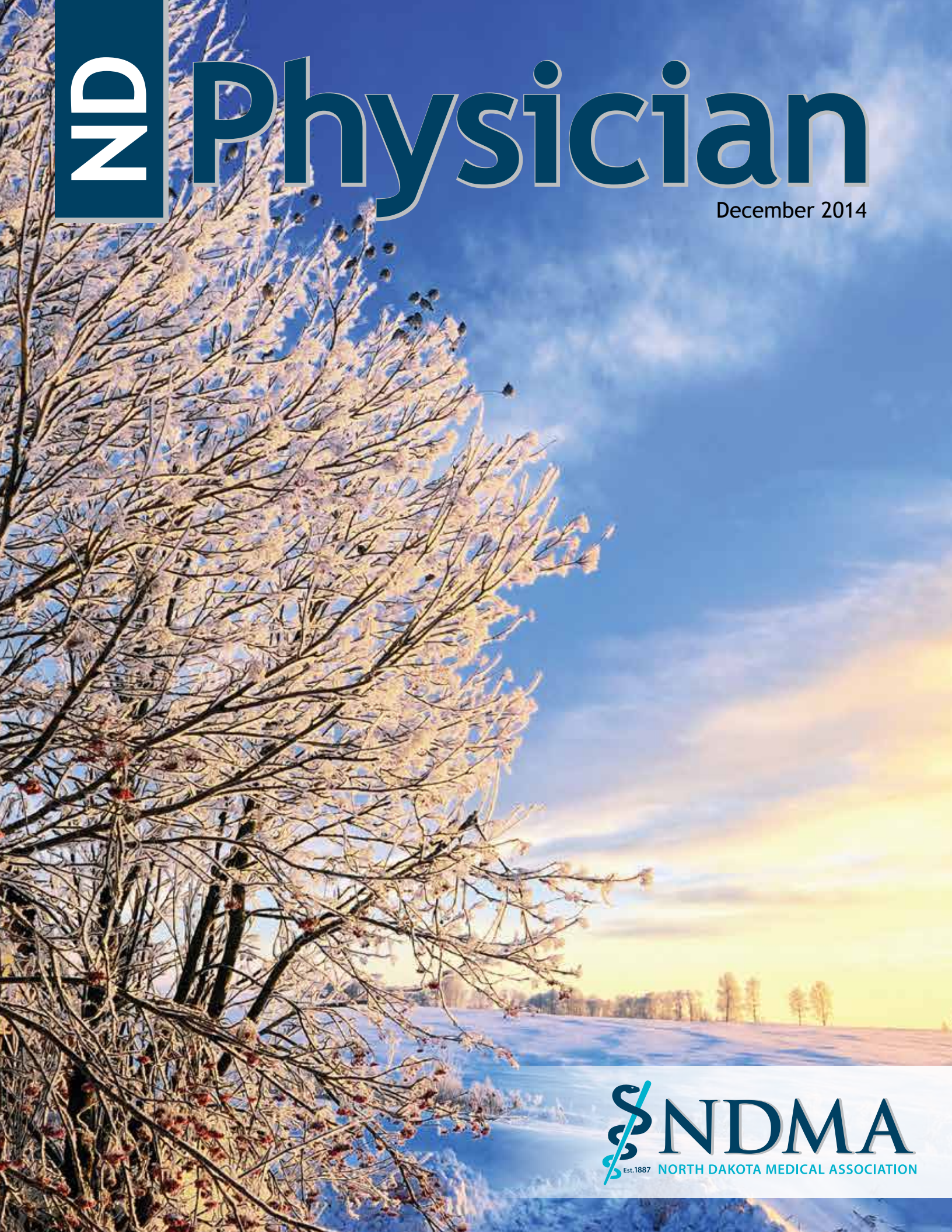
ND Physician

December 2014



NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

ND Physician

North Dakota Medical Association

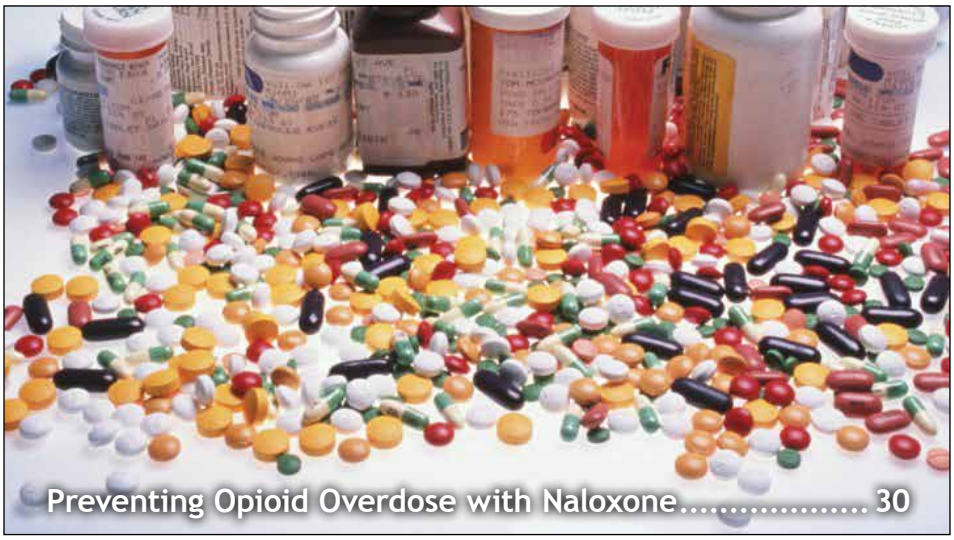
The mission of the North Dakota Medical Association is to promote the health and well-being of the citizens of North Dakota and to provide leadership to the medical community.

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

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

ND Physician is published by the North Dakota Medical Association, 1622 East Interstate Avenue
P.O. Box 1198, Bismarck, ND 58502-1198,
Phone: 701-223-9475 Fax: 701-223-9476
E-mail: staff@ndmed.com
Katie Fitzsimmons, Editor

In this Issue



Physician Advocate

Physician Satisfaction

When I was doing my medical school and residency training in Chicago, one of the large department store chains had an advertising campaign based on the slogan *'What Have You Done for Me Lately?'* Repeatedly I hear physicians say, "the AMA does not do anything for me." I would like to take a little time and talk about the AMA's Strategic focus to show what the AMA is doing for physicians. Details can be found on the AMA website.

"As the nation's health care system continues to evolve, the AMA is dedicated to ensuring sustainable physician practices that result in better health outcomes for patients. This work is captured in the AMA's five-year strategic plan, which aims to ensure that enhancements to health care in the United States are physician-led, advance the physician-patient relationship, and ensure that health care costs can be prudently managed."

The AMA's plan emphasizes three core areas of focus:

IMPROVING HEALTH OUTCOMES

"Since our founding in 1847 the American Medical Association has focused on the health of patients. As the health care system evolves, the AMA remains committed to answering the national imperative to measurably improve the health of the nation. It is doing so by tackling two of the nation's most prevalent issues: cardiovascular disease and type 2 diabetes."

ACCELERATING CHANGE IN MEDICAL EDUCATION

"With unprecedented change in health care delivery underway, transforming how physicians are trained in the United States is imperative. Envisioning the medical school of the future, the American Medical Association today is working across the medical education continuum to truly meet the needs of our nation's medical students, physicians, and patients by creating new models for learning and new methods and opportunities for collaborative innovation."

ENHANCING PROFESSIONAL SATISFACTION AND PRACTICE SUSTAINABILITY

I would like to especially spend some time to discuss the efforts to enhance professional satisfaction. Why would anyone other than physicians concern themselves with our satisfaction? We are respected in our communities and by the people we work with and the patients we care for, well paid, and generally pampered in our work place.

Several studies have reported a significant relationship between decreased physician satisfaction and greater work force attrition, which could reduce the size of the available physician work force. There is a strong positive correlation between physician satisfaction and patient satisfaction. Patient adherence to medical treatment shows a positive association with physician satisfaction. Greater physician satisfaction is associated with greater continuity of care and physicians who report great satisfaction have lower no-show and cancellations.

Everyone should care about physician satisfaction.

It is gratifying that apparently physician satisfaction does not correlate with the quality of care provided to patients. We are physicians, after all.

As a first step, the AMA collaborated with RAND Health, a respected national health care research firm, to identify the critical factors of success in care delivery and payment models that promote professional satisfaction and practice sustainability in different settings. It was decided that we needed data that was neutral and unbiased, thus an outside organization conducted the study.

Steven P. Strinden, MD

Several studies have reported a significant relationship between decreased physician satisfaction and greater work force attrition, which could reduce the size of the available physician work force.

What do we now know?

Demographic characteristics

In general, overall physician satisfaction is relatively high with the percentage of physicians reporting being very or somewhat satisfied ranging from 79-84 percent. A minority of physicians report dissatisfaction with their careers.

- There is an apparent relationship between age and satisfaction, with younger physicians (<35) and older physicians (>65) reporting the highest levels of satisfaction and middle-aged physicians reporting lower levels of satisfaction relative to those two groups
- Graduates of foreign medical schools report lower overall career satisfaction than graduates

In general, overall physician satisfaction is relatively high with the percentage of physicians reporting being very or somewhat satisfied ranging from 79-84 percent. A minority of physicians report dissatisfaction with their careers.

of medical schools based in the United States
- Studies of race offer differing and conflicting results
- Physicians practicing in rural locations generally report high overall satisfaction compared to non-rural locations
- Physicians in physician-owned practices or partnerships are more likely to be satisfied than those in other ownership models
- Pediatricians, geriatricians, dermatologists, and neonatologists are more likely to report overall satisfaction while otolaryngologists, obstetricians/ gynecologists, ophthalmologists, orthopedic surgeons, and internists were less likely to report overall job satisfaction
- Higher income has been associated with greater professional satisfaction however a slight drop in satisfaction is noted in the highest income brackets. A physician's perception of earning a 'fair"' income is one of the strongest indicators of overall satisfaction

Quality of care

When physicians perceive themselves as providing high quality care and meeting the needs of their patients, we are more satisfied. Conversely, obstacles to providing high-quality care are major sources of professional dissatisfaction.

- Being able to provide high quality care is commonly associated with having sufficient time with patients
- Physicians commonly express dissatisfaction when we perceive payers as hindering the quality of care we provide, either due to non-coverage of necessary services or preauthorization requirements

Autonomy and work control

Greater autonomy and greater control over the pace and content of clinical work are both associated with higher professional satisfaction. For some physicians, having a leadership or management role are both associated with professional satisfaction, however practice ownership is not for everyone and some physicians derive satisfaction from employed positions which allow them to focus more exclusively on clinical care.

- Physicians value having control over their work hours and schedules and express dissatisfaction when hours and schedules are perceived as overly rigid or when physicians do not have input into certain aspects of patient scheduling
- Physicians report that authority over certain financial decisions is especially important. Key among these are capital investments deemed necessary for patient care and the ability to determine salaries for physicians and staff

Practice leadership

Professional satisfaction is higher when physicians perceive that the organizational leadership shares the same values physicians do, particularly concerning approaches to clinical care. Having leaders with clinical experience enhances the sense of values alignment.

- Physicians report appreciating clear explanations when new initiatives require new limits on our autonomy

Professional satisfaction is higher when physicians perceive that the organizational leadership shares the same values physicians do, particularly concerning approaches to clinical care. Having leaders with clinical experience enhances the sense of values alignment.

- Physicians express dissatisfaction when practice leadership does not allow flexibility in implementing initiatives, particularly when leadership is perceived as mandating broad solutions without fully understanding how problems vary from provider to provider
- 88 percent of physicians report that their practice leaders respect them as professionals

Collegiality, fairness, and respect

Physicians' perceptions of collegiality, fairness, and respect are key determinants of professional satisfaction. Physicians note four main areas where these constructs operate: relationships with colleagues in their practice (including leadership), relationship with colleagues outside of their practice, relationship with patients, and relationship with payers.

- Some specialty-specific frustrations with unfairness and disrespect are noted. For surgeons these concerns are most prominently related to arranging hospital call duties. For primary care physicians, interactions with other physicians are most problematic when primary care physicians (and their staff) are treated as subservient
- Physicians describe the importance of being able to trust our colleagues with our patients. Collaborative teamwork involving physicians and other staff is a source of professional satisfaction. Difficulty transitioning to forms of teamwork that do not have physician leadership is often felt to be disrespectful
- Few physicians report being disrespected by their patients
- Certain tools used by payers (e.g. prior authorization) are felt to be disrespectful

Work quantity and pace

Challenges stemming from the quantity and pace of physician work are identified as dissatisfiers, especially in primary care practice. The pressure to provide greater quantities of services effectively limit the time and attention we can spend with each individual patient, detracting from the quality of care in some cases.

- Even outside of office visits, the work required to maintain large patient panels in primary care generates stress
- Importantly, some physicians report that dissatisfaction (and worries about practice sustainability) results from insufficient work quantity
- Separate from time pressure, physicians describe a tension between filling their patient care duties, keeping their length of working days manageable, and achieving acceptable work-life balance

Work content, allied health professionals, and support staff

In general, physicians describe better work satisfaction when their work content matches their training and dissatisfaction when they were required to perform work that other staff could perform; especially when they feel that the content of their work is being dictated to them.

- Working with adequate numbers of well-trained, trusted, and capable allied health professionals and support staff is a key contributor to greater physician satisfaction
- Support from such staff enables physicians to achieve a more desirable mix of work content
- Working with allied and support staff who perform key tasks- such as handling incoming messages and fulfilling patient requests- that do not require a physician's attention- can make important contributions to better professional satisfaction
- Greater staff stability is a significant predictor of overall professional satisfaction

Payment, income, and practice finances.

Few physicians report dissatisfaction with their current levels of income; however, physicians report that income stability is an overall contributor to overall professional satisfaction. Payment arrangements that are perceived as fair, transparent, and aligned with good patient care enhance professional satisfaction. Physicians are not tolerant of income reductions perceived as resulting from the poor business decisions of practice leaders.

- Physicians value having control over the amount of income that they earn and being able to make their own trade-offs between income and hours worked
- There is a general sense that relative incomes will shift in the future, with primary care gaining and some subspecialties potentially losing income

Regulatory and professional liability concerns

Physicians describe externally imposed rules and regulations under which we operate have predominantly negative effects on

In general, physicians describe better work satisfaction when their work content matches their training and dissatisfaction when they were required to perform work that other staff could perform.

THE PHYSICIANS FOUNDATION
Empowering Physicians Improving Healthcare

2014 Survey of American Physicians: Where is physician morale the highest and lowest?

The following chart displays the percentages of physicians who indicate their professional morale is very or somewhat positive by state. The remaining physicians indicate their morale is very or somewhat negative. Data derived from a survey of 20,088 physicians conducted for The Physicians Foundation by Merritt Hawkins.

1	North Dakota	58.1%	26	New York	44.3%
2	Minnesota	54.8%	27	Illinois	44.1%
3	Rhode Island	52.9%	28	Wyoming	44.1%
4	Virginia	52.9%	29	Pennsylvania	44.0%
5	West Virginia	52.9%	30	Alabama	43.9%
6	Maryland	51.3%	31	Michigan	43.6%
7	Massachusetts	51.0%	32	Oregon	43.0%
8	Wisconsin	50.4%	33	Tennessee	43.0%
9	Iowa	49.7%	34	South Dakota	42.8%
10	Idaho	49.2%	35	Ohio	42.7%
11	Utah	48.5%	36	New Hampshire	42.6%
12	California	48.0%	37	Colorado	42.3%
13	Kansas	48.0%	38	New Jersey	42.3%
14	Vermont	47.9%	39	New Mexico	41.3%
15	Kentucky	47.7%	40	Connecticut	41.1%
16	Nebraska	47.5%	41	Georgia	41.1%
17	Alaska	47.4%	42	Florida	40.9%
18	Oklahoma	46.1%	43	Arizona	39.8%
19	South Carolina	45.8%	44	Mississippi	39.8%
20	Washington	45.7%	45	North Carolina	38.8%
21	Delaware	45.3%	46	Texas	36.3%
22	Indiana	44.9%	47	Louisiana	35.7%
23	Missouri	44.9%	48	Nevada	32.8%
24	Hawaii	44.8%	49	Arkansas	32.4%
25	Maine	44.5%	50	Montana	29.4%

professional satisfaction. While we generally agree with the intent of the rules and regulations, there is great frustration with the time and documentation burdens these rules impose- especially when it is believed that we are being asked to generate new documentation of activities that we believe we have already performed.

- The "hassle factor" stemming from economic and regulatory forces external to the practice organization is significantly and negatively correlated with satisfaction
- Professional liability concerns are not prominent contributors to dissatisfaction. Recent state specific reforms may have contributed to this finding

Physicians describe having insufficient time to deliver what is perceived to be high quality care but at the same time describe spending significant time performing tasks that do not require a physician's training.

Health reform

Aside from incentives to adopt EHRs the study did not identify recent health reforms as prominent contributors to overall professional satisfaction, either positively or negatively.

EHR

EHR usability represents a unique and vexing challenge to physician professional satisfaction. We are going to address that in the next letter from the president.

THE PHYSICIANS FOUNDATION
Empowering Physicians Improving Healthcare

2014 Survey of American Physicians: How many physicians remain in private practice?

The following chart displays the percentages of physicians who remain in independent private practice by state. Data derived from a survey of 20,088 physicians conducted for The Physicians Foundation by Merritt Hawkins.

1	Louisiana	52.0%
2	Texas	48.6%
3	New Jersey	44.6%
4	Illinois	44.2%
5	Arkansas	43.3%
6	Hawaii	42.4%
7	Idaho	41.9%
8	Arizona	39.2%
9	Utah	38.2%
10	Tennessee	38.1%
11	Alabama	37.9%
12	Nevada	37.9%
13	Michigan	37.8%
14	North Carolina	37.7%
15	Connecticut	37.1%
16	South Carolina	37.0%
17	Georgia	36.5%
18	California	36.3%
19	Florida	36.2%
20	Wyoming	35.3%
21	Colorado	34.3%
22	Washington	33.7%
23	Mississippi	33.3%
24	Montana	33.3%
25	Oregon	33.3%
26	New York	33.2%
27	Rhode Island	32.9%
28	Virginia	32.9%
29	West Virginia	32.9%
30	Delaware	31.1%
31	Ohio	30.6%
32	Iowa	30.4%
33	Nebraska	29.6%
34	Pennsylvania	29.1%
35	Kentucky	28.6%
36	Kansas	28.3%
37	Maryland	27.6%
38	Missouri	27.6%
39	Oklahoma	25.8%
40	Maine	24.4%
41	Vermont	22.9%
42	Minnesota	22.7%
43	Massachusetts	22.6%
44	Alaska	19.4%
45	Indiana	19.2%
46	New Mexico	18.4%
47	New Hampshire	18.3%
48	South Dakota	16.7%
49	Wisconsin	12.0%
50	North Dakota	6.6%

Conclusions

Physicians describe having insufficient time to deliver what is perceived to be high quality care but at the same time describe spending significant time performing tasks that do not require a physician's training. Interventions that can allocate these tasks to other staff (or dispense with them altogether) may free a physician's time to devote to patient care tasks that do require our training; thus, improving quality of care, the patient care experience, and professional satisfaction.

Policies and procedures that allow physicians to participate in practice management may improve physician's sense of control over factors that directly affect their delivery of patient care.

When implementing new and different payment methodologies, the predictability and perceived fairness of physician incomes will affect physician satisfaction.

Reducing the cumulative burden of rules and regulations may improve professional satisfaction and enhance a physician's ability to focus on patient care.

The RAND Corporation study finds that physicians are more satisfied when we perceive that we are meeting our patient's needs by delivering high quality care-and dissatisfied when we perceive barriers to providing high quality care. When dissatisfaction stems from factors that physicians perceive as compromising quality, further investigation of these factors may help identify important opportunities to improve patient care

The AMA and RAND Corporation have marvelously articulated the factors impacting physician's professional satisfaction and I have liberally borrowed their words.

You can find the full report online: *www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR439/RAND_RR439.pdf*

Your care team is now just a tap away.

DocbookMD is a free benefit for NDMA members.

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

Available on the App Store

Get it on Google play

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

docbookMD

NDMA NORTH DAKOTA MEDICAL ASSOCIATION

NDMA in Action

NORTH DAKOTA MEDICAL ASSOCIATION Est.1887

North Dakota 2015 Legislative Session Preview

Courtney M. Koebele, JD

Governor Dalrymple revealed his 2015-2017 budget to state legislators on December 3, 2014. We were pleased to hear that the governor provided for a Medicaid increase of four percent for all providers. His budget included unprecedented expenditures of $5 billion. The budget recommendations represent an increase of 5.4 percent in General Fund appropriations compared to the current biennium. The governor indicated that the vast majority of this increase in General Fund appropriations is necessary to address the growing demand for state resources and essential services. NDMA will work with the North Dakota Hospital Association and the North Dakota Long term Care Association to ensure the 4% is included in the final budget adopted by the 2015 Legislative assembly.

The number of bills affecting healthcare will be increasing throughout the next several weeks, until the deadline for final bill submittal in January 2015.

The number of bills affecting healthcare will be increasing throughout the next several weeks, until the deadline for final bill submittal in January 2015. However, several bills, developed by the interim committees, have been adopted by Legislative Management and will go forward in the 2015 Legislative Session in the follow areas:

Health Care Delivery in General and the Affordable Care Act bills:

- *Health Care Delivery System Study:* This bill provides for Legislative Management to continue its ongoing study of the needs and challenges of the state's health care delivery system. The study may include monitoring the implementation of the Affordable Care Act, examining Medicaid Expansion and Medicaid reform, and considering the feasibility of developing a state-based plan for a health care model that will comply with federal health care reform in a manner that will provide high-quality access and affordable care for North Dakota citizens. The University of North Dakota School of Medicine and Health Sciences Advisory Council shall make periodic reports to the Legislative Management on the status of the biennial report developed pursuant to Section 15 52-04.

- *Programs to Assist Health Professionals Report:* This bill directs the State Department of Health during the 2015-16 interim to evaluate state programs to assist health professionals, including behavioral health professionals, with a focus on state loan repayment programs for health professionals. During the 2015-16 interim, the State Department of Health shall make periodic reports to the Legislative Management on the outcome of the study, including presentation of recommended legislation.

- *Medicaid Expansion Contracts:* This bill amends the Medicaid Expansion law to provide if the Department of Human Services implements the Medicaid Expansion program through a contract with a private carrier, the department shall issue one request for proposal for the health insurance component of Medicaid Expansion and shall issue one request for proposal for the pharmacy benefit management component of the Medicaid Expansion or shall provide the pharmacy benefit management services through the Department of Human Services. The bill provides if the pharmacy benefit management component is not provided through the Department of Human Services, the contract between the department and the pharmacy benefit manager must include specified provisions that address pass-through pricing, transparency, and audit provisions.

- *Medicaid Cost-Sharing Report:* This bill directs the Department of Human Services during the 2015-16 interim to study options for implementing income-based cost-sharing provisions for the Medicaid and Medicaid Expansion programs. This study must include consideration of provider recovery rates for co-payments, information technology capacity for implementing income-based cost-sharing provisions, consideration of how income-based cost-sharing has been implemented by other states, analysis of the costs and benefits of cost-sharing, and consideration of whether cost-sharing improves the effectiveness of Medicaid and Medicaid Expansion programs. Before July 1, 2016, the Department of Human Services shall report to the Legislative Management the outcome of the study and the associated legislative recommendations and related draft legislation.

- ***Study of State Employee Health Insurance Premiums:*** This concurrent resolution provides for a Legislative Management study of state contributions to state employee health insurance premiums, including the effect of the federal Affordable Care Act on the state uniform group insurance program.

- ***Community Paramedic Services Reimbursement:*** This bill requires the Department of Human Services to adopt rules entitling licensed community paramedics to payment for health-related services provided to recipients of medical assistance, subject to limitations and exclusions the department determines necessary, consistent with limitations and exclusions of other medical assistance services.

- ***Dental Services Study:*** This resolution directs the Legislative Management to continue to study dental services in the state, including the effectiveness of case management services and the state infrastructure necessary to cost-effectively use mid-level providers to improve access to services and address dental service provider shortages in underserved areas of the state.

Telemedicine

- ***Telemedicine Insurance Coverage:*** This bill outlines that the Public Employees Retirement System (PERS) uniform group insurance must provide medical benefits coverage under a policy that provides coverage for health care services provided by a health care provider or health care facility by means of telemedicine which are the same as the policy coverage of in-person health care services provided by a health care provider or health care facility. The mandate is limited to the PERS system, the mandate expires in two years, the bill directs PERS to study the impact of the bill during that two-year period, and the bill directs PERS to introduce to the 65th Legislative Assembly a bill to extend the mandate of coverage to the private health insurance market.

Behavioral Health – the interim Human Services committee commissioned a study of North Dakota's behavioral health system. An unprecedented number of bills to address several issues raised by the study were adopted by the committee and will be studied in more detail during the 2015 session:

- ***Substance Abuse Insurance Coverage:*** The bill amends the group health policy mandate for substance abuse coverage. The bill applies the substance abuse coverage requirements to all health insurance policies; removes the coverage requirement formulas for different types of substance abuse services; and clarifies required coverage must include inpatient treatment, treatment by partial hospitalization, residential treatment, and outpatient treatment.

Governor Dalrymple revealed his 2015-2017 budget to state legislators on December 3, 2014. We were pleased to hear that the governor provided for a Medicaid increase of four percent for all providers.

- ***Involuntary Commitment:*** The bill revises the involuntary commitment proceeding law to update the language and to expand the statutory authority of advanced practice registered nurses to authorize advanced practice registered nurses to act as independent expert examiners in involuntary commitment proceedings.

- ***Behavioral Health Licensing Boards Oversight:*** This bill establishes an oversight system and reciprocity language for behavioral health licensing boards.

- ***Behavioral Health Professional Loans and Grants:*** This bill provides appropriations to the State Board of Higher Education, the Bank of North Dakota, and the Department of Human Services for forgivable loans and grants relating to certain behavioral health professionals.

- ***State Hospital and James River Correctional Center Master Plan:*** This bill provides an appropriation to the Department of Human Services to develop a master plan in conjunction with the Department of Corrections and Rehabilitation for the State Hospital and the James River Correctional Center.

- ***Addiction Treatment Services Vouchers:*** This bill provides an appropriation to the Department of Human Services for a voucher system for addiction treatment services.

- ***Behavioral Health Services:*** This bill provides medical assistance coverage for behavioral health services provided by licensed marriage and family therapists and licensed professional clinical counselors and directs the Department of Human Services to develop an outcomes-based data system for behavioral health services. This bill also provides an appropriation to the Department of Human Services for adult and youth substance abuse treatment services, provides an appropriation to the Highway Patrol for mental health first aid training for state and local law enforcement personnel, and provides for a Legislative Management study of the structure and services of the Department of Human Services during the 2015-16 interim.

- ***Qualified Mental Health Professionals:*** This bill expands the definition of qualified mental health professional as it relates to residential treatment centers for children.

NDMA will work with the North Dakota Hospital Association and the North Dakota Long term Care Association to ensure the 4% is included in the final budget adopted by the 2015 Legislative assembly.

- *Behavioral Health Assessment and Training:* This bill provides appropriations to the Department of Human Services for an adult and youth mental health assessment network and a pilot project to develop planning protocols for discharge or release of individuals with behavioral health issues and to the Department of Public Instruction to provide mental health first aid training for teachers and child care providers. This bill also provides for a Legislative Management study of mental health screening and assessment programs for children and continues the study of behavioral health needs of youth and adults in the 2015-16 interim.

- *Mental Health Professionals and Personnel:* This bill includes licensed marriage and family therapists in the definitions of mental health professional and mental health personnel, as they relate to commitment procedures and judicial remedies.

- *Behavioral Health Judicial Issues:* This bill provides for a Legislative Management study of judicial issues related to behavioral health, including 24-hour hold, termination of parental rights, and court committals, during the 2015-16 interim.

Autopsies and Death Investigation:

- *Death Investigation Training and Planning:* This bill provides appropriations to the State Department of Health for information technology costs related to the electronic review of death records and for the reimbursement of travel costs related to county coroner training and planning meetings.

- *Death Investigation Services Study:* This resolution directs the Legislative Management to continue to study medicolegal death investigation in the state and how current best practices, including authorization, reporting, training, certification, and the use of information technology and toxicology, can improve death investigation systems in the state.

Brain Injury:

- *Traumatic Brain Injury Registry:* This bill provides appropriations to the State Department of Health for a traumatic brain injury registry and to the Department of Human Services for traumatic brain injury registry marketing and training, traumatic brain injury regional resource facilitation, and brain injury services, including return to work programming.

- *Brain Injury Study:* This resolution provides for the Legislative Management to continue the study of a comprehensive system of care for individuals with brain injury during the 2015-16 interim.

- *Traumatic Brain Injury Flex Fund:* This bill provides an appropriation to the Department of Human Services for a traumatic brain injury flex fund program.

Opioid Issues:

- *Workers' Compensation Coverage of Chronic Opioid Therapy:* This bill establishes protocols that must be followed as a prerequisite for Workforce Safety and Insurance to cover chronic opioid therapy for injured employees. To qualify for coverage, the chronic opioid therapy must be appropriate and meet specified requirements; the status of the injured employee must meet specified requirements, such as have a diagnosis consistent with chronic pain; and the prescriber of the chronic opioid therapy shall meet specified requirements, such as complying with documentation requirements and entering treatment agreements with the injured employee.

In this last month before session, several provider groups have proposals that are seeking to expand their scope of practice or establish licensure. NDMA is currently reviewing all proposals.

- *Naturopathic Expansion of Scope* – The naturopathic doctors, who first received licensure in 2011, wish to expand their scope of practice to include prescribing, suturing, and naturopathic childbirth.
- *Acupuncturists* – wish to create licensure under the Board of Integrative Health, with the title "acupuncturist" and abbreviation "L.Ac.". This licensure is supported by the Naturopathic doctors.
- *Radiologic Technologists* – wish to create a state licensure board for medical imaging and radiation therapy professionals. They seek licensure to allow medical imaging professionals to receive verbal orders and record them in the patient's medical record.
- *Medical Psychologists* – although no bill has been introduced, NDMA and the North Dakota Psychiatric Society (NDPS) has been approached with a proposal to allow licensure of medical psychologists. NDPS has concerns about prescribing by practitioners without the proper medical training. NDPS and NDMA will be monitoring this issue closely.
- *Licensed Addiction Counselors* – The department of corrections seeks to allow psychologists, or masters degree level social workers, to engage in addiction evaluation services, when consistent with the individuals professional standards and code of ethics.

Other Bills that will likely be filed:

Concern from NDMA Annual Meeting:

- *Class C Felony for Assault of a Health Care Provider:* At the 2014 NDMA House of Delegates, the North Dakota chapter of emergency physicians introduced a resolution to provide for a higher penalty when a health care provider is assaulted in the scope of their employment. This relatively minor change to the assault law would provide for a class C felony charge.

Opioid and overdose issues:

- *Good Samaritan bill* – to protect individuals from prosecution if they contact law enforcement and reported a medical emergency due to a drug overdose.
- *Naloxone immunity bill* – to provide immunity from liability related to opioid antagonists and limited prescriptive authority for Naloxone rescue kits.
- *PDMP utilization* – A bill to require licensing boards of all prescribers to establish rules for utilization of the Prescription Drug Monitoring program.
- *Peer Review Panel for Evaluation of Pharmaceutical Narcotic Review* – there has been interest in establishing an organized, professional, and multi-disciplinary peer-review panel to evaluation of referred cases with pharmaceutical narcotic practices in order to recognize trends, provide recommendations for system improvements, and improve health care quality relating to pharmaceutical usage.

AARP:

- *CARE Act:* The AARP of North Dakota is asking the legislature to support the Caregiver, Advise, Record, Enable (CARE) Act. The act requires the name of the family caregiver be recorded when the patient is admitted to the hospital. The caregiver is notified if the patient is discharged and the facility must provide an explanation and a demonstration of the medical tasks that the caregiver will perform.

Workforce Safety and Insurance:

- *Health Care Provider opinions:* WSI seeks an amendment to the workers compensation law to allow health care providers to disclose information or render options regarding an injured employee's condition to WSI. This disclosure, in itself, would not be the basis for a disciplinary action.

Tobacco Tax:

- Based on a 2013 HOD Resolution, NDMA is part of a coalition to support a bill to raise the tobacco tax.

As you can see, there are a number of bills that will be affecting the practice of medicine. If you see any issue that you would like to learn more about, please to not hesitate to contact Courtney Koebele or Katie Fitzsimmons.

Continuing the UND SMHS's Healthful Resolutions in the New Year

News from the Dean of the UND SMHS

Joshua Wynne, MD, MBA, MPH

The biennial legislative session is set to begin next month, and I'd like to provide an update regarding the School's budget requests that will be considered by the 64th Legislative Assembly. As you probably know, the School of Medicine and Health Sciences (SMHS) submits its budget to the University of North Dakota (UND), and through the university, to the State Board of Higher Education (SBHE). It is the SBHE that presents its overall higher education budget (including the SMHS) to the Legislature. The very good news is that the School is not requesting a single new or additional dollar beyond what was approved previously by prior assemblies (other than the standard cost-of-living increases requested by UND). We have two important requests, though, that are in addition to our base funding request—one to complete the new building construction, and one to continue funding for the Healthcare Workforce Initiative (HWI). As you may recall, the 63rd Legislative Assembly provided half of the approved funding for the building or about $62 million during the last session. The second half of funding is needed now. As things stand at present, I'm pleased to report that the construction project is on time and on budget. We anticipate that the building will be completed, occupied, and ready for students who will arrive in the summer of 2016. If you haven't had a chance to visit the construction site in Grand Forks recently, you'd be amazed at the rapid progress of the project. To see live video of where things stand now, please visit this website *http://oxblue.com/open/pcl/UNDSMHS.*

The School's other major budget request is for continued funding of the HWI, North Dakota's plan to address the state's healthcare workforce challenges by reducing disease burden, retaining and training more healthcare workers, and improving the efficiency of our healthcare delivery system by training the next generation of healthcare workers to work together more effectively as members of interprofessional teams. Our funding request for the coming biennium is identical to what we presented to the 63rd Legislative Assembly two years ago—to the dollar. So I think that the School is managing both big projects well; both the building project and the HWI are on target—and on budget!

As part of the HWI, we are substantially increasing class sizes. And that means we need more faculty members to teach the additional students and residents. Recruitment to North Dakota often is a challenge, even in our good economic times. But the School is achieving success in recruitment—currently we have about a half-a-dozen recruits who have or are close to signing agreements with us. I hope to have a full report regarding recruitment in my next column.

We continue to work with the medical school accrediting body—the Liaison Committee on Medical Education (LCME)—to ensure that we are responding appropriately to the citations noted in our last LCME visit in March 2014. As you may recall, we were cited for compliance issues regarding around eight percent of the more than 130 LCME standards. We have developed an Action Plan to ensure compliance with all of the standards, and the School is awaiting approval of its Action Plan by the LCME. We anticipate receiving such approval in February 2015, and we will then have about six months or so to demonstrate that we are making real progress in addressing the findings related to noncompliance with 10 standards. We do not anticipate any major difficulty in being able to address the LCME's concerns, and expect to be in full compliance with all standards by the end of 2015. Assuming that all goes as anticipated, the School's next LCME full-survey visit should occur right on schedule in the first quarter of 2022.

In closing, thanks again to all of you who are involved in teaching our medical and health sciences students and residents. We couldn't do it without you, and we are all deeply grateful for your contributions.

My wife Dr. Susan Farkas and I wish you all good things in the New Year. All the best to you and yours this holiday season!

Booth New Associate Dean for the Southwest (Bismarck) Campus at UND School of Medicine and Health Sciences

GRAND FORKS, N.D.—A. Michael Booth, MD, PhD, was named associate dean for the Southwest (Bismarck) Campus at the University of North Dakota School of Medicine and Health Sciences in September of 2014. Booth is a cardiovascular and thoracic surgeon. He practices at the St. Alexius Heart and Lung Clinic in Bismarck.

Booth succeeded Dr. Nicholas Neumann as Southwest Campus dean. Neumann is retired at the end of September.

"Dr. Booth has been an outstanding faculty member at UND for the past 25 years, and has coordinated the surgical clerkship at the Southwest Campus for years," said Joshua Wynne, MD, MBA, MPH, UND vice president for health affairs and dean of the UND School of Medicine and Health Sciences. "He has a strong commitment to medical education and will be devoting about half of his professional time to this new position. I am thrilled that he has accepted our offer to be the next Southwest campus dean."

Booth, a native of Fulton, New York, graduated from Johns Hopkins University, where he was elected to membership in Phi Beta Kappa, the nation's oldest and most widely recognized honor society. He earned his Doctor of Medicine from Johns Hopkins University and completed his surgery residency at the University of Minnesota, where he served as chief resident and was the recipient of a National Institutes of Health National Research Award. He earned his PhD in Physiology from the University of Minnesota School of Medicine.

Booth has practiced with St. Alexius since 1989. He began teaching in the Department of Surgery at the UND School of Medicine and Health Sciences in 1989, where he is a clinical professor of surgery. In 2000, the School honored Booth with the Wayne Swenson Teaching Award in Surgery. He was elected by the School to be a member of the Alpha Omega Alpha Honor Medical Society, which recognizes and advocates for excellence in scholarship and the highest ideals in the profession of medicine.

He has served as president of the North Dakota Medical Association, the North Dakota Chapter of the American College of Surgeons, and the Sixth District Medical Society of the NDMA.

Booth is board-certified by the American Board of Surgery and the American Board of Thoracic Surgery. He also is certified in cardiac pacing and cardioversion defibrillation. He is a fellow of the American College of Surgeons, the American College of Cardiology and American College of Chest Physicians. He is also a member of the Society of Thoracic Surgeons, Association for Surgical Education, and North Dakota Medical Association. Booth has published over 20 articles on cardiovascular physiology and thoracic surgery.

DOCTOR OF THE DAY

YOU CAN SIGN UP BY CLICKING HERE

The 2015 NDMA Doctor of the Day Program begins January 14, 2015, and continues into April. This is an excellent opportunity for you to observe the 2015 North Dakota Legislative Assembly in action and involve family members if you wish.

As the Doctor of the Day, the physician provides primary care services to legislators and staff in a designated room at the capitol, where basic exam equipment and OTC medications are available. Coverage is usually needed from 8:30 am to 3:30 pm daily, but may be tailored to your availability. The physician is given a pager, allowing you to observe the legislative session. Physicians are not expected to respond to medical emergencies while in the Capitol. These are important services appreciated by legislators, and provide physicians with significant visibility among legislators throughout the session.

NDMA will again provide hotel accommodations as necessary for those volunteers from outside of Bismarck-Mandan who may need to arrive the night before their service.

NDMA members wishing to sign up for the Doctor of the Day Program may do so at any time by choosing a day available to you by completing the signup form (click here) or by calling the NDMA office at 1-800-732-9477 or 223-9475.

Summary of the Annual Interim AMA Meeting

A Report from our AMA Delegate

Alternate Delegate Shari Orser, MD, Vice-President Debra Geier, MD, AMA-RFS Delegate and AMA-RFS Sectional Delegate Paul Bahal, MD, NDMA executive director Courtney Koebele, and I attended the Annual Interim meeting in Dallas November 8 – 11, 2014. Attendees heard a special address from an expert from the Centers for Disease Control and Prevention (CDC), who told physicians that the chance of encountering patients with Ebola in ambulatory settings is very low, but physicians need to be prepared nonetheless. VA Secretary Robert A. McDonald told physicians that the U.S. Department of Veterans Affairs (VA) is working to right wrongs, reframe perceptions, and enhance care for veterans and in order to be successful, the VA needs the help of physicians.

Policies addressed at the meeting included:

Maintenance of Certification

Physicians voted to update the AMA's policy on maintenance of certification. The adopted policy outlines principles that emphasize the need for an evidence-based process that is evaluated regularly to ensure physician needs are being met and activities are relevant to clinical practice.

Medicaid Expansion

Delegates voted to support Medicaid expansion and encourage lawmakers to identify realistic coverage options for adults currently in the coverage gap, even if states choose not to adopt the Medicaid expansion outlined in the Affordable Care Act.

The North Dakota AMA Delegation in Dallas (L-R): Paul Bahal, MD; Courtney Koebele, JD; Rob Beattie, MD; Deb Geier, MD; and Shari Orser, MD

Robert Beattie, MD

Public Health Issues

- *Called for the AMA to continue to be a trusted source of information and education on urgent epidemics or pandemics affecting the U.S. population. The policy was enacted in the wake of the Ebola outbreak in West Africa*
- *Reinforced its support for regulatory oversight of electronic cigarettes. Delegates also supported regulations that would establish the minimum legal purchase age for electronic cigarettes to be 18 years old, place marketing restrictions on manufacturers, and prohibit claims that electronic cigarettes are effective tobacco cessation tools. Supported efforts to give the U.S. Food and Drug Administration authority and funding to effectively oversee the manufacturing, marketing and sale of dietary supplements*
- *Urged the increased use of sobriety checkpoints and called for state medical societies to overturn bans on using them to deter driving under the influence*
- *Passed policy recognizing the important role of pharmacists in vaccinating target populations that lack access to a medical home or that otherwise are unlikely to receive immunizations through physician practices. The policy affirms that health professionals who administer vaccines have shared responsibilities to ensure that vaccination administration is documented in the patient medical record. Further, it calls on physicians and pharmacists to work together in the community to encourage patients to follow up with a primary care physician to ensure continuity of care*

Interstate Medical Licensure Compact to Streamline Medical Licensure

The AMA HOD voted to support the Interstate Medical Licensure Compact. The model legislation was developed by the Federation of State Medical Boards (FSMB) to make it easier for physicians to obtain licenses in multiple states

while providing access to safe, quality care.

Under the new policy, the AMA will work with interested medical associations, the FSMB, and other stakeholders to ensure expeditious adoption of the compact and the creation of an Interstate Medical Licensure Commission.

The compact, which was released in July, is based on several key principles, including:

- *The practice of medicine is defined as taking place where the patient receives care, requiring the physician to be licensed in that state and under the jurisdiction of that state's medical board. This tenant aligns with the principles for telemedicine that were developed by the AMA Council on Medical Service and adopted at the 2014 AMA Annual Meeting.*
- *Regulatory authority will remain with the participating state medical boards, rather than being delegated to an entity that would administer the compact.*
- *Participation in the compact is voluntary for both physicians and state boards of medicine.*
- *New policy calls for adequate networks for patient access, choice*

Provider Networks

New policy was adopted aimed at addressing inadequate provider networks so patients have access to the care they need and the physicians they rely on.

The new AMA policy, which is part of a new report by the AMA Council on Medical Service, calls for health insurers to make changes to their provider networks before the open enrollment period gets underway each year. Implementing changes to provider networks at this time will help prevent patients from being stuck with plans that drop their physicians after they already have enrolled.

Other aspects of the policy included:

- *Promoting state regulators as the primary enforcers of network adequacy requirements*
- *Calling for insurers to submit quarterly reports to state regulators*
- *Calling on insurers to treat patient visits to out-of-network physicians the same as in-network visits (if the plan's provider network is deemed inadequate and supporting regulation and legislation that require out-of-network expenses to count toward a patient's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits or is forced to go out of network as a result of network inadequacies.*

Meaningful Use Penalties

AMA delegates renewed their request that the Centers for Medicare and Medicaid Services suspend penalties for failure to meet meaningful use criteria. The new policy comes on the heels of the recent release of new attestation numbers showing only 2 percent of physicians have demonstrated Stage 2 meaningful use so far this year. In response to the new figure, the AMA joined with other health care leaders to urge policymakers to take immediate action to fix the meaningful use program by adding more flexibility and shortening the reporting period to help physicians avoid penalties.

In addition to calling for EHRs to be more interoperable, physicians also are recommending that policymakers ease regulations to allow for EHRs to become more usable.

The DEA has been busy!

Mark Hardy, Pharm D, Assistant Executive Director, ND Board of Pharmacy

Hydrocodone Containing Products (HCPs) Moved to Scheduled II Controlled Substances

The anticipated release of the Drug Enforcement Administration (DEA) final rule which adjusted all hydrocodone containing products (HCPs) from Schedule III to Schedule II became effective on October 6, 2014. The justification from the DEA was based on a current analysis by the DEA and Health and Human Services which indicated that HCPs have a high potential for abuse and the abuse leads to severe psychological or physical dependence, which is the criteria for placing a substance in Schedule II. The process of rescheduling was initiated in 1999 by a physician. Comments from the public were taken with a small majority approving the change in scheduling of the HCPs.

HCPs are overwhelmingly the top narcotic drug dispensed. According to the North Dakota Prescription Drug Monitoring Program, in 2013 over 208,000 prescriptions for HCPs were dispensed accounting for a total quantity of nearly 11 million dosage units.

This certainly caused a ripple effect of issues across the medical community. This action of the DEA to modify the class of a narcotic medication is a unique one. The DEA did allow pharmacies to honor refills of prescriptions written before the October 6th date if state laws allowed. This action helped ease the transition for practitioners and patients to this change.

As you are aware, the law for issuing a Schedule II vs. a Schedule III prescription are different. Let me highlight a few options for issuance of a Schedule II prescription.

- Prescription must be manually signed (pen in hand signature) and pharmacy requires a hard copy of prescription
- A faxed prescription is only valid when the patient is a hospice patient or resides in a licensed long-term care facility and if the prescription has been signed by the practitioner before faxing, the facsimile may serve as the original prescription without another signature
- Verbal prescriptions are not valid, unless under a bona fide emergency situation, in which the practitioner directly transmits the prescription to the pharmacist and a follow up written and signed prescription is sent to the pharmacy within 7 days
- Electronic prescribing of Schedule II prescriptions is allowed (see below)

Electronic Prescribing of Controlled Substances

The DEA issued a rule, effective June 1, 2010, permitting electronic prescriptions for controlled substances. A true electronic prescription is transmitted as an electronic data file to the pharmacy. The data file is imported into its database, where it is electronically stored. Prescribers will be required to obtain authorization credentials, which will be two-factor. Two-factor authentication requires two of the following: something you know (a password), something you have (a hard token), or something you are (biometric identification). Prescriber and pharmacy e-prescribing software must be certified prior to being used. We do have some limited examples of software systems in North Dakota being certified to transmit and accept controlled substance prescriptions. I anticipate once this is widely utilized with software systems it will ease much of the hassle surrounding the issuance of controlled substance prescriptions, especially for Scheduled II substances.

DEA Releases rule to allow Pharmacies to register as take back locations.

The Drug Enforcement Administration (DEA) released their Final Rule for the Disposal of Controlled Substances, which implements the Secure and Responsible Drug Disposal Act of 2010. The DEA developed and implemented regulations that outline methods to transfer unused or unwanted pharmaceutical controlled substances to authorized collectors for the purpose of disposal.

Effective October 9, 2014, the following entities may be authorized collectors for the operation of a take-back or disposal program: retail pharmacies (defined as any entity registered with the DEA as a retail pharmacy), hospitals and clinics with on-site pharmacies, narcotic treatment programs, registered manufacturers, distributors, and reverse distributors. The new rule also permits retail pharmacies and authorized hospitals and clinics to place collection receptacles at long-term care facilities.

Prior to the passage of the Act, there were no legal provisions for patients to dispose of unwanted pharmaceutical controlled substances except to give them to law enforcement. The North Dakota Attorney General currently operates a very successful Take Back program in which many of the local sheriff's offices across North Dakota are able to accept and dispose of controlled substances from patients.

This rule will allow authorized registrant to add a provision to their DEA registration to be allowed to be a registered take back location. The Board of Pharmacy has been discussing with various take back vendors to determine if they can assist in getting our pharmacies set up with a program in which they can maintain for the public.

Better Blood Pressure, No Added Burden: One Practice's Story From the American Medical Association

A Chicago-area physician has achieved a 90 percent control rate for his hypertension patients in the past year by working with his medical assistant, nurse, and other staff members to execute standardized blood pressure protocols in the practice.

Family medicine physician Michael K. Rakotz, MD, is using a team-based care approach to improve hypertension control in his office. Dr. Rakotz is part of a pilot program of the AMA's Improving Health Outcomes initiative, which involves physicians and their teams at multiple clinic sites in two states. Participating practices are incorporating evidence-based principles into their workflows to control hypertension.

Since the start of the pilot, Dr. Rakotz's practice has seen a double-digit leap in the number of hypertensive patients who have their blood pressure controlled, moving from 78 percent to 90 percent in 12 months. He attributes the practice's success to the work of his practice staff, who have been trained in a standardized checklist approach to measuring blood pressure.

Dr. Rakotz's medical assistant (MA) follows a procedure to measure accurately. If an initial automated reading shows that blood pressure is elevated, she follows a specified protocol using an automated machine that takes multiple readings over six minutes, with no staff in the room to reduce the "white coat" effect on the patient's blood pressure. If these readings indicate the patient has high blood pressure, the MA flags this information for Dr. Rakotz.

"All of this occurs before the physician enters the room, so the system is very efficient," Dr. Rakotz said. "It does not add any burden to the physician."

The practice also has a strong home-monitoring program for patients whose blood pressure management requires more clinical data. Practice staff give these patients a special checklist that explains how to properly position themselves for measurement as well as when and how often they should be measuring their blood pressure. Staff can validate and check the accuracy of patients' personal blood pressure machines or lend patients machines that record a week's worth of blood pressure readings.

Practice staff enters all data from patients' home monitoring into the practice's electronic health record system.

"This brings actionable information to the physician before the physician even walks into the exam room," Dr. Rakotz said. "Those kinds of little innovations, little empowerments of the staff, make the system function really well."

He also employs a nurse to take charge of patient outreach.

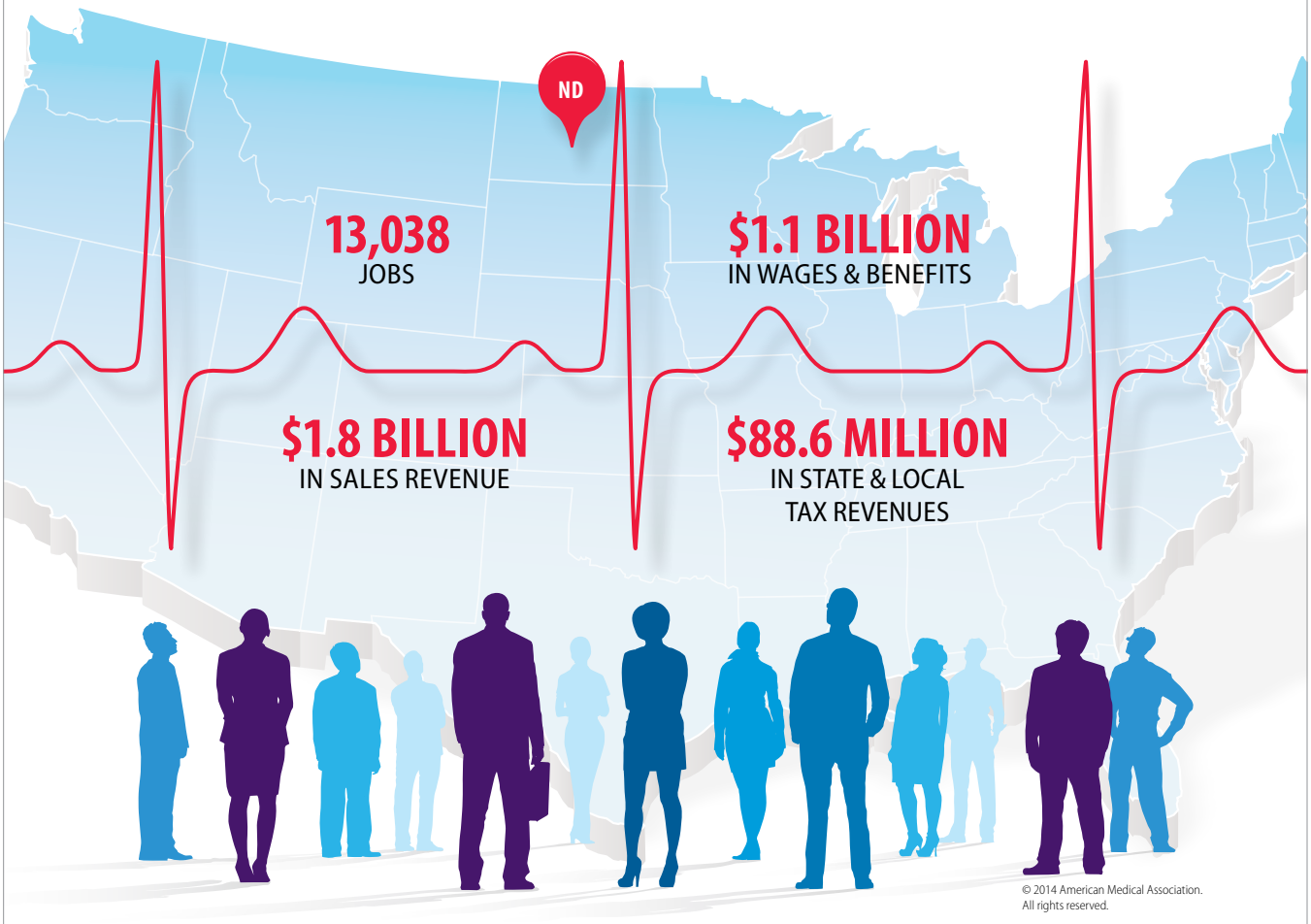
The challenge up front is training staff to understand and appropriately implement checklists and protocols. After that, "it's autopilot," Dr. Rakotz said.

"Physicians are so overwhelmed with meaningful use criteria, insurance authorizations, paperwork, and forms—all this nonclinical care," he said. "Anything our staff can do to help us is huge. The more time I have to care for patients, the better. I want [my staff] to be smart and follow protocols using common sense. If someone has high blood pressure, I want my staff to know what to do. I want them to follow a set of guidelines."

The AMA pilot is working with researchers at Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality and the Johns Hopkins Center to Eliminate Cardiovascular Health Disparities to develop test protocols, including the one Dr. Rakotz uses. The tools are being refined before being made available to physicians across the country.

"Even if you're in a more rural, smaller practice, the more time you invest in training your staff up front, the more dividends you're going to get on the back end in quality of care," Dr. Rakotz said.

PHYSICIANS BOOST THE ECONOMY.



See the effect in North Dakota.

The American Medical Association 2014 Economic Impact Study, completed in conjunction with the North Dakota Medical Association, shows how much physicians add to the economic health of North Dakota.

Check the effect physicians have on the U.S. economy by viewing the national report from the AMA, as well as highlights from the North Dakota study, at **ama-assn.org/go/eis**.

AMA
AMERICAN MEDICAL ASSOCIATION

NDMA
NORTH DAKOTA MEDICAL ASSOCIATION

Please activate your 2015 AMA membership. Visit ama-assn.org/go/join or call (800) 262-3211.

The Hospital Association and NDMA: Partners at the Capitol

Jerry Jurena
President, North Dakota Hospital Association

During the 2013 Legislative Session the North Dakota Hospital Association (NDHA) and the North Dakota Medical Association worked together every day to assure the physicians, hospitals, and individuals we provide care to were treated fair. Before the session even began, Courtney and I met with the President of the North Dakota Long Term Care Association to determine if there were issues common to all three Associations. One issue that crossed all three associations was an inflator on our reimbursement. After each of us met with our respective members and visited with key legislators, we agreed that what was passable was a 4% increase. We went forward with our committed goal and were successful.

For the 2015 session, we proceed with the same format and again we came to a consensus that we believe is achievable. Courtney and I continue to collaborate on issues and to review draft bills that affect the physicians, the hospitals, or both. In the upcoming session, NDHA has listed the following priorities:

- Inflator, 4% each year of the biennium
- Workforce shortages, at all levels across the state. The number one listing at Job Service is RNs
- Infrastructure; having appropriate sized hospitals especially in outpatient services areas to meeting the growing demands:
  - We are requesting a 1% low interest loan fund to be used on capital projects, especially in rural hospitals
  - We will be supporting funding for additional housing
  - We will be supporting funding for daycare
- We will be supporting additional in-state workforce for behavior/mental health
- We will be asking for adequate reimbursement to sustain behavior/mental health services across the state
- Reimbursement for e-health will be a focus
- Bad debt relief caused by increased demand on hospital ERs due to oil boom, statewide
- Keep and maintain Medicaid Expansion:
  - Current enrollment over 14,000; from DHS
  - Estimated $158 million benefit to state; from DHS
  - Reduction in Bad debt of $68 million to hospitals; from DHS
  - 100% funded until 2017 then decreases to 90% in 2020
- Support the commitment by the Legislature to fund the second half the School of Medicine construction project

This is by no means an all-inclusive list. What we have found is that, as the session moves along new issues continue to surface and we must be ready and flexible to meet those challenges at that time. As we look forward to the session starting on January 6, know that NDMA and NDHA will continue to work as partners in order to provide the best care to North Dakotans.

News About the North Dakota Professional Assistance Program, Inc.

The Board of Directors of the North Dakota Professional Assistance Program, Inc. (NDPAP) is happy to announce that Tammy King, MSW, CRC has been hired as the Executive Director and Dr. Barrie March, MD, has been contracted to be the Medical Director of the program. The office, in Bismarck, will be completed soon with the anticipation of being able to move in the first week of December.

The NDPAP is a state-wide non-profit organization providing help for physicians and physician's assistants affected by addictive disease and mental or emotional illness. The NDPAP acts as an advocate and care manager through: confirmation of impairment issues, intervention, assessments, referral to treatment facilities, aftercare monitoring, and advocacy.

More information regarding contact information, program details and the referral process will be provided in the very near future once the program is operational.

A Recap of NDMA's 127th Annual Meeting:

Technology & Today's Physician

We are pleased to report that NDMA hosted another successful Annual Meeting. Over 55 physicians, guests, award recipients, and staff attended the 127th meeting in Grand Forks at the Hilton Garden Inn. We were honored by the presence and presentations of our guest speakers and with the education they provided, which offered two hours of CME credit to all participants. This year, we enrolled a new conference schedule: the program was condensed into one day. We received positive reviews on this format and are looking forward to evaluating its merits as we plan next year's meeting in Bismarck.

Dean Joshua Wynne, MD, MBA, MPH, the University of North Dakota's vice president for health affairs and dean of the UND School of Medicine and Health Sciences, presented an update on the School of Medicine, the accreditation process that was recently completed, the movement on construction of the new building, and the progress on the Healthcare Workforce Initiative. Dean Wynne expressed his gratitude toward North Dakota physicians for contributing their time to North Dakota's medical students. His column in this issue delves into his talking points of that day.

Dr. Maya Babu, MD, MBA, and representative of the AMA Board of Trustees, attended the NDMA Council meeting and presented an AMA update to the House of Delegates. Dr. Babu's presentation reviewed AMA's strategic plan and goals. Those goals include improving health outcomes for patients, accelerating change in medical education, and increasing physician satisfaction and practice sustainability. Dr. Babu shared new applications and tools that are in the process of being developed and distributed which assist patients in meeting their health goals and physicians in their medical practice.

Courtney Koebele and NDMA President, Dr. Steve Strinden

Misky K. Anderson, DO, NDMA Speaker of the House, convened the House of Delegates and reviewed the seven presented resolutions; all seven were adopted with minimal adjustments but much discussion. No new resolutions were introduced. We included the full script on each of the resolutions in this issue for easy

Picture of the NDMA House of Delegates Meeting on Friday, October 3

reference. You can also access them on our website.

Trish Lugtu from the Midwest Medical Insurance Company (MMIC) presented two CME courses titled, Dispelling the Myth: Cyber Risk is not a Technology Problem and Managing Physician Reputations: When Your Online Reputation is On the Line. In this time of pervasive technology and ample information, it is important that physicians understand how to best utilize available technology in everyday practices with their care teams. Furthermore, managing your online reputation can be a full time job. Ms. Lugtu provided methods of troubleshooting these issues.

Besides all the learning and procedure, there was fun to be had. The annual lunch and awards presentation, emceed by NDMA President Steve P. Strinden, MD, was fantastic. We honored our physicians who hit the 40-year mark in practice, including Davis L. Bronson, MD; Norman T. Byers, MD; William D. Canham, MD; Ajitkumar S. Damle, MD; Stanley T. Diede, MD; Paul J.T. Fetterly, MD; Walter E. Frank, MD; Steven K. Hamar, MD; Bernard J. Hoggarth, MD; Richard E. Johnson, MD; Stephen A. Korte, MD; Timothy J. Mahoney, MD; Richard J. Marsden, MD; Nicholas H. Neumann, MD; Russell W. Petty, MD; Gregory J. Post, MD; Philip S. Sedo, MD; Bradford A. Selland, MD; James W. Vanlooy, MD; and Allen E. Wyman, MD.

Our Physician Community and Professional Services Award recognition was awarded to Roger Schauer, MC FAAFP. The award recognizes outstanding members of the Association who serve as role models, active in both their profession and in their community. Dr. Schauer embodied all of that and more during his career; NDMA was honored to present this award to such a deserving, well-known, and well-respected physician and scholar.

Dr. Schauer was a physician leader in the state for 40 years; he recently retired in June of 2014. Kimberly T. Krohn, MD, MPH, FAAFP, nominated Dr. Schauer for this award because she "doubts that there are very many nominees for this award who are as dedicated to North Dakota and to the profession of medicine as Dr. Roger Schauer is." Dr. Krohn presented the award to Dr. Schauer in front of his wife Jan, and all those present at the luncheon.

NDMA Friend of Medicine Award winner, Dave Molmen, with Dr. Casey Ryan

Dr. Kim Krohn presenting Dr. Roger Schauer with the 2014 NDMA Physician Community and Professional Services Award

40 Years of Service Award Winners (L-R): Dr. Norman Beyers, Dr. Walter Frank, Dr. Steven Hamar, Dr. Tim Mahoney, and Dr. Gregory Post

After graduating from the University of North Dakota and Wayne State University School of Medicine and completing a Residency at Hennepin County Medical Center in Minneapolis, Dr. Schauer practiced in Hettinger, ND, and served as the Medical Director of the Ambulance Service in New England, ND. Dr. Schauer became a clinical assistant professor at the UND School of Medicine in 1979 and he was, for the past 18 years, the associate professor in the education scholar track in the Department of Family and Community Medicine at the School in Grand Forks. He was the Director of the Family and Community Clerkship for the School for the past 22 years, and, in that role, interfaced with nearly every rural community in North Dakota that has a medical presence. Quite notably, he created and directed the Rural Opportunities in Medicine Education (ROME) program. Dr. Schauer secured grants for the School, in addition to presenting at conferences, being a published scholar, serving as a peer reviewer, fulfilling leadership roles within professional societies and organizations, and receiving many honors from health-based groups all over the state.

Dr. Schauer truly exemplified physician leadership throughout his career; NDMA is privileged to have Dr. Schauer as one of the outstanding physicians recognized by this award.

UND President Dr. Robert Kelley, NDMA Executive Director Courtney Koebele, and UND SMHS Dean Dr. Joshua Wynne

Dr. Kimberly Krohn of Minot with Dr. Maya Babu

Dave Molmen, Chief Executive Officer of Altru Health System, was recognized with NDMA's Friend of Medicine award. The Award formally acknowledges non-physician citizens of the state who "have distinguished themselves by serving as effective advocates for health care, patient services, or the profession of medicine in the state of North Dakota." Mr. Molmen has been improving the state of health care since 1978. Mr. Molmen is a graduate of Concordia College and the University of Minnesota. He is the former Chief Operating Officer for Altru Health System and United Hospital, former Chief Executive Officer of Midwest Medical Group in Denver, Colorado, former Associate Administrator of Grand Forks Clinic, and the former Administrator of the Grand Forks Orthopedic Clinic. In his current role as Chief Executive Officer, he provides business management leadership and oversees Altru's non-physician staff in addition to serving as the Chair of the North Dakota School of Medicine and Health Sciences Advisory Council.

Dr. Casey Ryan, a physician at Altru Health Systems, nominated Mr. Molmen for this award. In Dr. Ryan's nomination letter, he noted that "Dave was instrumental in getting legislative approval for the new University of North Dakota School of Medicine and Health Sciences building. Dave has always been a physician advocate in his leadership roles." NDMA is honored to have Dave Molmen grace its list of award recipients.

After all the awards were presented and speeches were made, Dr. Robert O. Kelley, President of the University of North Dakota, welcomed the group to Grand Forks and addressed UND SMHS's accreditation process, the construction projects on campus, and how UND SMHS is working with the state's physicians to produce well-educated and experienced doctors to serve North Dakota.

We understand that participating in the Annual Meeting can be difficult to manage, but those that attended found the investment of time worth the effort. With many complicated issues lacing the practice of medicine, talking with others in the field and gaining greater perspective from outside entities proved fruitful for all attendees. We are working on 2015's Bismarck Meeting and we hope to set a date soon. Stay tuned for updates and information!

RESOLUTION NO. 1

Resolution No. 1
Introduced By: NDMA Council
Subject: Interstate Licensure Compact

1) WHEREAS, medical licensure can be a cumbersome and time-
consuming process for physicians practicing
2) in or moving among multiple states; and
3) WHEREAS, improving the efficiency and time required to
license a physician can expedite placement of a
4) physician who is needed to care for patients especially in high
demand practice and shortage areas; and
5) WHEREAS, an interstate physician licensure compact could
positively impact the mobility of physicians in
6) meeting patient demand for access to healthcare; and
7) WHEREAS, the Federation of State Medical Boards developed
an Interstate Medical Licensure Compact,
8) that complements the existing licensing and regulatory
authority of state medical boards, provides a
9) streamlined process that allows physicians to become licensed
in multiple states, thereby enhancing the
10) portability of a medical license and ensuring the safety of
patients; and
11) WHEREAS, the Compact creates another pathway for licensure
and does not otherwise change a state's
12) existing Medical Practice Act; and
13) WHEREAS, the Compact also adopts the prevailing standard for
licensure and affirms that the practice of
14) medicine occurs where the patient is located at the time of
the physician-patient encounter, and therefore,
15) requires the physician to be under the jurisdiction of the state
medical board where the patient is located;
16) and
17) WHEREAS, state medical boards that participate in the
Compact retain the jurisdiction to impose an adverse
18) action against a license to practice medicine in that state
issued to a physician through the procedures in
19) the Compact; and
20) WHEREAS, to become a member state of the Compact, the
Interstate Medical Licensure Compact must be
21) adopted by the state legislature.
22) THEREFORE, BE IT RESOLVED BY THE 2014 HOUSE OF
DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION
23) that NDMA encourage the North Dakota Board of Medical
Examiners to consider and propose adoption
24) of the Interstate Medical Licensure Compact.

RESOLUTION NO. 2

Introduced By: ND Chapter of American
College of Emergency Physicians
Subject: Assault Against a Health Care Providers

1) WHEREAS, the American Medical Association supports
increased protection against violence toward
2) healthcare providers, including the apprehension and
prosecution of persons who commit acts of assault
3) on healthcare providers performing in a professional capacity;
and
4) WHEREAS, the increase in population in North Dakota has
brought an increase in crime and assaults in the
5) workplace against health care providers; and
6) WHEREAS, violence in a healthcare setting is becoming more
widespread, accounting for 60% of
7) workplace assaults; and
8) WHEREAS, current North Dakota Law provides for Class C
Felony classification for assault against an
9) emergency department worker in the performance of the
member's duties; and

10) WHEREAS, these additional protections should be extended to
all health care providers engaged in official
11) duties.
12) THEREFORE, BE IT RESOLVED BY THE 2014 HOUSE OF
DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION
13) that the North Dakota Medical Association, seek legislation
that provides for a class C felony assault
14) classification when a person willfully or negligently causes
physical injury to a healthcare provider when
15) the person knows or has reason to know that the victim is a
healthcare provider engaged in official duties.

RESOLUTION NO. 3

Introduced By: NDMA Council
Subject: Safe Injection Practices

1) WHEREAS, the use of safe injection practices through the use
of sterile techniques is a fundamental
2) obligation of healthcare practitioners in the protection of
patients against the transmission of infectious
3) disease; and
4) WHEREAS, the failure of healthcare practitioners in North
Dakota to utilize safe injection practices have
5) been proven to result in the transmission of infectious disease;
and
6) WHEREAS, the impact on individuals who were infected has
been severe, the confidence in the healthcare
7) system to safeguard patients has been compromised, and the
impact on public health has been great.
8) THEREFORE, BE IT RESOLVED BY THE 2014 HOUSE OF
DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION
9) that the North Dakota Medical Association encourage safe
injection techniques be promoted and
10) maintained in all hospitals, clinics, private practices, nursing
homes, and other medical care settings in
11) North Dakota; and
12) BE IT FURTHER RESOLVED that the North Dakota Medical
Association encourage healthcare practitioner
13) licensing boards to require safe injection practices training
upon initial licensure and annual thereafter by
14) means of an approved program that meets the guidelines of
the centers for disease control; and that such
15) training will be documented by each agency, institution, or
office where healthcare practitioners are
16) employed.

RESOLUTION NO. 4

Introduced By: Commission on Ethics
Subject: Disrespect and Derogatory Conduct
in the Patient-Physician Relationship

1) WHEREAS, the American Medical Association has affirmed
principles regarding patient rights in E-10.01
2) Fundamental Elements of the Patient-Physician Relationship;
and
3) WHEREAS, the American Medical Association has affirmed
principles regarding Physician and patient
4) conduct in Ethical Opinion 9.123, "Disrespect and Derogatory
Conduct in the Patient-Physician

5) Relationship"; and
6) WHEREAS, the relationship between patients and physicians is based on trust and should serve to promote
7) patients' well-being while respecting their dignity and rights. Trust can be established and maintained
8) only when there is mutual respect; and
9) WHEREAS, physicians recognize the importance of patient autonomy, including a patient's right to choose
10) his or her physician. Physicians further recognize the importance of ensuring that each patient has an
11) identified physician responsible for the patient's care; and
12) WHEREAS, patients who use inappropriate language or actions toward physicians seriously undermine the
13) integrity of the patient-physician relationship and there needs to be appropriate institutional mechanisms
14) to address abusive behaviour by patients, appropriate psychiatric referral or consultation as a part of the
15) treatment plan if the abusive conduct is a consequence of a mental disorder and an appropriate mechanism
16) to ensure continuity of care for a patient who persistently declines care from the responsible health care
17) provider.
18) THEREFORE, BE IT RESOLVED BY THE 2014 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION
19) that the NDMA will encourage health care organizations to develop best practices for attending to abusive
20) patients and encourage development of guidelines for health care providers to follow in non-life
21) threatening situations when they encounter patients who verbally abuse or threaten physical abuse

RESOLUTION NO. 5

Introduced By: NDMA Council
Subject: Behavioral Health

1) WHEREAS, one in four adults (approximately 61.5 million Americans) experience a mental illness
2) in a given year; and one in 17 adults (about 13.6 million Americans) live with a serious mental
3) illness such as schizophrenia, major depression or bipolar disorder; and
4) WHEREAS, serious mental illness costs America $193.2 billion in lost earnings per year and mood
5) disorders such as depression are the third most common cause of hospitalization; and
6) WHEREAS, suicide is the tenth leading cause of death in the United States (more common than
7) homicide) and is the third leading cause of death for ages 15 to 24 years, resulting in
8) approximately 100 deaths by suicide per day in the United States; and
9) WHEREAS, approximately 60 percent of adults received no mental health services in the previous
10) year; and
11) WHEREAS, the treatment of mental illness is effective in saving and improving lives and when
12) there is the opportunity to get proper treatment, then recovery to a productive life is possible.
13) THEREFORE, BE IT RESOLVED BY THE 2014 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL
14) ASSOCIATION that NDMA advocate in the 2015 legislative session to significantly increase
15) funding to the ND Department of Human Services so as to increase and improve the delivery of
16) mental health services throughout our state.

RESOLUTION NO. 6

Introduced By: Robert Beattie, MD
NDMA Delegate to the American Medical Association
Subject: Support of Iowa Medical Society Resolution to the AMA House of Delegates on Access and Equity in Telemedicine

WHEREAS, the North Dakota Medical Association is a member of an AMA regional caucus founded in 1943 called the North Central Medical Conference; and

WHEREAS, the North Central Medical Conference is comprised of the following states: Iowa, Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin; and

WHEREAS, the Iowa Medical Society Delegation will introduce a resolution on the subject of *Access and Equity in Telemedicine Payments* at the American Medical Association House of Delegates 2014 Interim Meeting (Appendix A), urging the AMA to establish policy that there should be no geographic adjustment in payments for telemedicine, and lobby Congress to require the Centers for Medicare & Medicaid Services (CMS) to: 1) pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined "shortage" areas, if that area can show a shortage of those physician specialists; and 2) eliminate geographic adjustments for telemedicine payment to providers; and

WHEREAS, the Iowa Medical Society Delegation has requested the North Dakota Medical Association support the resolution.

THEREFORE, BE IT RESOLVED BY THE 2014 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION that the North Dakota Medical Association support the introduction of the resolution *Access and Equity in Telemedicine Payments* at the American Medical Association House of Delegates 2014 Interim Meeting (Appendix A).

Appendix A
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution ___ (I-14)
Introduced by: Iowa Delegation
Subject: Access and Equity in Telemedicine Payments
Referred to:

Whereas, All Americans deserve access to quality health care, including telemedicine if they are not able to easily access health care locally; and

Whereas, Physician specialty availability is shrinking to dangerous levels in some areas of the country, especially after 5:00 p.m.; and

Whereas, Medicare reimbursement for telemedicine is not available in areas that are not considered "shortage" designated areas, defined as rural Health Professional Shortage Areas (HPSAs) as those located in rural census tracts as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration (HRSA) where ''rural'' includes certain geographic areas located in rural census tracts within Metropolitan Statistical Areas (MSAs) allowing for broader inclusion of sites within HPSAs as telehealth originating sites; and

Whereas, Many areas of the country have shortages of some specialists even in those not designated as shortage areas, e.g., Metropolitan Statistical Areas; and

Whereas, Centers for Medicare & Medicaid Services (CMS) policy is that telemedicine payment for the physician is to be paid according to the geographic location where the physician is located; and

Whereas, Cost of telemedicine equipment is no different from one geographic area to another; and Whereas, Practice costs for telemedicine are primarily based on the provider's time; and

Whereas, Paying higher telemedicine rates to out-of-state physicians could exacerbate shortages of physicians in states with lower payment rates; and
Whereas, Physician time and work should not be devalued geographically; therefore, be it

RESOLVED, The AMA will establish as policy that there should be no geographic adjustment in payments for telemedicine, and lobby Congress to require the Centers for Medicare & Medicaid Services (CMS) to: 1) pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined "shortage" areas, if that area can show a shortage of those physician specialists; and 2) eliminate geographic adjustments for telemedicine payment to providers.

RESOLUTION NO. 7

Introduced By: Robert Beattie, MD
NDMA Delegate to the American Medical Association
Subject: Support of Iowa Medical Society Resolution to the AMA House of Delegates on Price Transparency

1) WHEREAS, the North Dakota Medical Association is a member of an AMA regional caucus founded
2) in 1943 called the North Central Medical Conference; and
3) WHEREAS, the North Central Medical Conference is comprised of the following states: Iowa,
4) Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin; and
5) WHEREAS, the Iowa Medical Society Delegation will introduce a resolution on the subject of *Price*
6) *Transparency* at the American Medical Association House of Delegates 2014 Interim Meeting
7) (Appendix A), urging the AMA to: 1) develop an educational program by early 2015 for physicians
8) that would make healthcare price and reimbursement site differences clear; and 2) work with the
9) Center for Healthcare Transparency (CHT), the Health Care Cost Institute (HCCI), and the Centers
10) for Medicare & Medicaid Services (CMS) to make their websites easier to access and use, and make
11) their data for hospital and physician prices and payments more accurate and useful for physicians,
12) purchasers, and patients; and
13) WHEREAS, the Iowa Medical Society Delegation has requested the North Dakota Medical
14) Association support the resolution.
15) THEREFORE, BE IT RESOLVED BY THE 2014 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL
16) ASSOCIATION that the North Dakota Medical Association support the introduction of the resolution
17) *Price Transparency* at the American Medical Association House of Delegates 2014 Interim Meeting
18) (Appendix A).

Appendix A
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution ____ (I-14)
Introduced by: Iowa Delegation Subject: Price Transparency
Referred to:

---

1) WHEREAS, Physicians are being asked to be more cost-conscious by many different payers, including our
2) government; and
3) WHEREAS, Patients are increasingly facing more cost-sharing in health insurance products, including the
4) Affordable Care Act public exchange products; and
5) WHEREAS, Physicians are asked to help patients avoid financial harm by choosing their tests and treatments
6) wisely; healthcare prices, depending on site of care, can vary ten-fold or more; and
7) WHEREAS, There is a lack of transparency regarding healthcare prices and costs; and
8) WHEREAS, The Centers for Medicare & Medicaid Services (CMS) has published data on hospital and physician
9) payments but the figures are not complete or accurate, and websites are very difficult to navigate and find
10) usable data; and
11) WHEREAS, The Center for Healthcare Transparency (CHT) and Health Care Cost Institute (HCCI) will be
12) publishing transparent data on healthcare costs soon; and
13) WHEREAS, Physicians who might be making decisions on where they may choose to practice (such as hospital-
14) employment vs. independent practice) have had little information on the differences in reimbursement for
15) different sites of care; and
16) WHEREAS, Physicians in Accountable Care Organizations (ACOs) need to know the prices of many different
17) services and the differences in cost for sites of care; therefore, be it
18) RESOLVED, That our AMA will: 1) develop an educational program by early 2015 for physicians that would
19) make healthcare price and reimbursement site differences clear; and 2) work with the Center for Healthcare
20) Transparency (CHT), the Health Care Cost Institute (HCCI), and the Centers for Medicare & Medicaid
21) Services (CMS) to make their websites easier to access and use, and make their data for hospital and
22) physician prices and payments more accurate and useful for physicians, purchasers, and patients.

New Name, Same Mission

Quality Health Associates of North Dakota

Effective September 1, 2014, North Dakota Health Care Review, Inc. (NDHCRI) officially changed its name to Quality Health Associates of North Dakota (QHA). This new name is a more accurate reflection of the organization today. Over the past 40 years, our services have grown well beyond our original role as a peer review organization for Medicare and now encompasses a much broader array of quality health improvement services. One thing that has not changed is our mission. We remain strongly committed to our work to continually improve health and healthcare for the people of North Dakota.

— Barbara Groutt, Chief Executive Officer

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

The conversation is not about dying, it's about how you want to live until the very end

Although more than 90 percent of people believe it is important to talk with family, friends, and providers about their wishes for care at the end of life, fewer than 30 percent of people actually have that discussion. (Source: National survey by The Conversation Project, 2013). The reasons for this disparity between what we want and what we do are fairly obvious. It is a difficult subject to discuss. Not many of us, and not many physicians, are trained on how to have this conversation. It is the inevitable outcome of life that many of us would rather not think about. But it is also clear from a growing body of studies that people who do have conversations with their families and physicians about their end of life preferences are far more likely to have those preferences honored. There is growing recognition that it is not enough to just have an advanced medical directive or living will. We need to have these important conversations with our loved ones and those we entrust with our care.

Since early 2013, at the request of the NDMA and the North Dakota Long Term Care Association, QHA has been facilitating the organization and development of a statewide coalition focusing on improving the end of life care experience for the people of North Dakota. What began as a conversation among a small group of committed individuals has now grown into the North Dakota Advanced Care Planning Coalition (NDACP) with more than 70 members representing 42 organizations, including health care professionals, community service providers, clergy, educators, lawyers, professional associations, interested stakeholders, and consumers. Through a series of meetings and conference calls the group has developed a set of objectives that include:

- Establishing a statewide collaborative to promote advance care planning conversations and documentation of preferences for care
- Creating a culture where end-of-life conversations become the norm through community and professional education, outreach, and discussion forums
- Providing continuous advance care planning with the understanding that complex decisions must be based on the clinical context and the evolving goals of care and needs of individuals
- Developing a standardized process that integrates individual preferences into medical orders
- Making documented preferences accessible across care settings
- Identifying and developing core competencies for health professionals related to advance care planning by:
    - Implementing an educational plan for practicing health professionals
    - Integrating these competencies into the curriculum of educational programs across the state

Honoring Choices North Dakota

After looking at how a number of other states have approached comprehensive advanced care planning initiatives, the NDACP formally adopted the Honoring Choices model originally used by the Twin Cities Medical Society in the Minneapolis area. Honoring Choices is designed to spur family conversations about future health care preferences and to assist health care organizations and community partners with the

installation of a comprehensive advanced care planning program. This model utilizes the training, principles, and methodology of the Respecting Choices model developed by the Gundersen Lutheran Health System in Lacrosse, Wisconsin, but allows for local adaptation of tools, materials, and approaches to best fit the needs of the local populations. Core to the Honoring Choices model is the training of individuals as instructors and conversation facilitators. Facilitators are trained to lead end of life care planning discussions with patients and families. Instructors certified by Respecting Choices can provide ongoing development and training of conversation Facilitators.

As with all coalitions comprised of volunteer members, sustainability for the NDACP will hinge on developing a strong organizational structure and the acquisition of funding. The Coalition's governance and organizational structure is in the process of being finalized, and the entire coalition membership is exploring multiple funding options. In addition to these efforts, QHA recently applied for a HRSA Rural Outreach grant which, if successful, would support the training and deployment of multiple Instructors and Facilitators throughout health care systems and communities in rural areas of North Dakota.

If you are interested in joining the NDACP, or would like more information about this initiative, please contact:

Sally May, RN, BSN, CH-GCN
Quality Health Associates of North Dakota (QHA)
3520 North Broadway
Minot, ND 58703
(701) 852-4231
smay@qualityhealthnd.org

North Dakota Family Physician of the Year: Kimberly Krohn, MD, MPH, FAAFP

Kimberly Krohn, MD, MPH, FAAFP, was selected as the North Dakota Family Physician of the Year award winner. Dr. Krohn is an active member of the NDAFP, AAFP, and NDMA. She is always encouraging residents, students, and colleagues to get involved in their local medical societies. She has served as President of the NDMA and is the current director for the UND Center for Family Medicine – Minot residency program. She has testified before committees of the state legislature on matters pertaining to Family Medicine topics. She is dedicated to furthering the education of the next generation of medical students and residents.

Dr. Krohn believes in leading by example. She has an active full spectrum family medicine practice in addition to her leadership responsibilities. She still delivers her own obstetrical patients and follows the babies as they grow up. She has multigenerational families in her practice and has patients to whom she has been their doctor for their entire lives. She still admits her own patients to the hospital and follows them to the nursing home. She exemplifies the 'from birth to death' ideal of Family Medicine. She still does home visits on her patients and encourages residents to do home visits on patients to whom a trip to the clinic is a challenge. She is active in Trinity Hospital committees and serves on the Medical Executive Committee, Medical Information and Technology Committee, and Education Committee. She is Vice Chair of the Quality Improvement Committee and Vice Chair of the Department of Medicine at Trinity Hospital. Dr. Krohn is a deputy assistant county coroner for Ward County and she does child abuse exams for the Northern Plains Children's Advocacy Center. She is Vice President of the Minot Rotary Club.

Dr. Krohn is an instructor for the ALSO (Advanced Life Support in Obstetrics) course. She continues to do research projects and usually involves resident so they develop their research skills and are exposed to poster presentations at National Meetings. She has been the champion for the national APGAR Asthma Screening research project at our clinic for the past several years.

Dr. Krohn is a role model for the students, residents, and colleagues who are privileged enough to work with her. Her passion and enthusiasm for being a Family Medicine physician are evident. She is an outstanding candidate for the Family Physician of the Year award.

For questions concerning this information, please contact Brandy Jo Frei, North Dakota Academy of Family Physicians Executive Director, at 701-772-1730.

Dr. Charles (Chuck) Breen of Hillsboro presenting Dr. Kimberly Krohn with the North Dakota Family Physician of the Year Award.

Honoring Choices MINNESOTA

TWIN CITIES MEDICAL SOCIETY

Executive Summary

Honoring Choices Minnesota is a collaborative, community-based initiative led by Twin Cities Medical Society through its East Metro Foundation. The medical society serves as the convener and coordinator, utilizing its unique access to health care organizations and medical professionals. Beginning in the Twin Cities metropolitan area and spreading across the state, Honoring Choices Minnesota's goal is to spur family conversations about future health care preferences and to assist health care organizations and community partners with the installation of a comprehensive advance care planning program. The nationally and internationally recognized model is being used: Respecting Choices, based out of Gundersen Lutheran Health System in La Crosse, WI. Honoring Choices Minnesota uses the training, principles and overall methodology of Respecting Choices, with Minnesota-specific governance, health care directive and patient education materials. This effort has grown into a movement and is a truly remarkable example of how both health care and non-health care organizations can work together to provide better medical care for Minnesotans.

Advance care planning is not merely the completion of a health care directive document or living will. Instead, it is a thoughtful process, ideally utilizing a certified advance care planning Facilitator who has been trained to engage patients in discussions with loved ones about their desires and values for future health care treatment decisions. The result of these conversations is usually a health care directive document. Honoring Choices Minnesota promotes the importance of these ongoing conversations.

Background

In 2008, Twin Cities Medical Society convened two exploratory meetings—one with community members and the second with senior leaders of hospital systems and health plans. The purpose of both meetings was to gauge the interest level in collaborating and coordinating resources related to advance care planning. Community members wholeheartedly agreed that there was a need, and senior leadership gave their unanimous support to:

1. not compete;
2. provide resources to support an initiative; and
3. advocate internally within their respective organizations and advance the initiative.

The medical society then formed an advisory committee and began to set the framework for the community collaborative. In 2009, a name and logo were selected, patient education materials were ordered from Gundersen Lutheran, and educational events began. A new Minnesota-specific health care directive was developed by the advisory committee and is available online at no charge in five languages. The advisory committee also began collaborating with related groups and efforts such as the Institute for Clinical Systems Improvement (ICSI), MN POLST (Provider Orders for Life Sustaining Treatment) workgroup, and National Healthcare Decisions Day.

Health care organizations pilot Honoring Choices Minnesota

Organizational commitment to Honoring Choices Minnesota was obtained from a number of Twin Cities health care systems in 2009. Fifty health care leaders attended a two-day course led by faculty members from Respecting Choices along with Honoring Choices Minnesota Medical Director, Kent Wilson, MD. Attendees were equipped with tools and resources to prepare their organizations for launching pilot sites. Organizations chose patient population(s) for piloting the program and identified individuals to be trained as advance care planning Facilitators and as Instructors. (Facilitators lead advance care planning discussions with patients and their families. Instructors serve as in-house experts who train new Facilitators and help guide organizational advance care planning efforts.) Work flows were defined and discussions occurred regarding the process of referrals to Facilitators and which quality measures to collect.

There were seven pilot sites operating during the first half of 2010. Honoring Choices Minnesota staff conducted regular check-ins with the pilot sites to offer opportunity for feedback and collaboration. The first Sharing the Experience Conference, held in July 2010, allowed all sites to convene and report on their findings. More training was held that fall and five new pilots began during the first six months of 2011. In 2012, two additional pilots began, one of which is a financial services organization offering advance care planning as an employee benefit.

One critical aspect to the success has been the input of local leaders from Allina Health and Park Nicollet Health Services, who lead comprehensive advance care planning programs within their organizations and have been involved in the work of Honoring Choices Minnesota from the onset. They serve on the advisory committee and provide their wisdom and experiences to the pilot programs.

Growth

Honoring Choices Minnesota has been widely accepted throughout the health care community and will continue to provide training and resources. In fact, other states are adopting our name, resources and structure. Patient education materials have been developed jointly with several local health care systems and are being used widely. Additional organizations continue to come forward with interest in pursuing this model within their system.

Our collaborative work is supported partially through the medical society and East Metro Foundation, as well as through funders who have enabled a more substantial effort and allowed public engagement to move ahead. Partnerships now exist beyond the traditional health care community and include ethnic, cultural and religious representatives, social services organizations, senior services groups, foundations and other organizations. Our hope is for all of the Twin Cities, and eventually the state, to understand the importance of advance care planning and be familiar with Honoring Choices Minnesota as a resource.

Community engagement

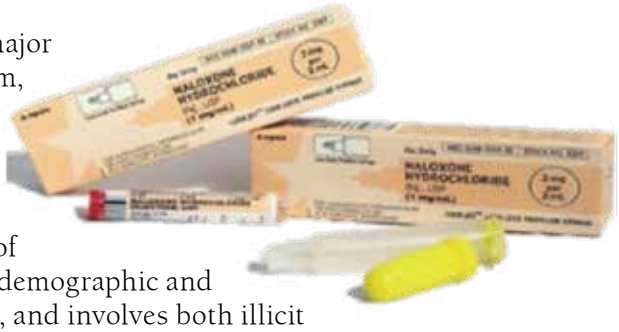
Honoring Choices Minnesota in partnership with Twin Cities Public Television (TPT) has created a collection of 700 online videos clips and tools designed to help Minnesota families have conversations about end of life care and advance care planning. Six documentaries aired on TPT and are available online, which are designed to inspire viewers to take action with advance care planning and obtain resources to guide family conversations.

A joint project has been established with the Minnesota Council of Churches, bringing advance care planning into faith communities in several places around the state.

The Honoring Choices Minnesota Ambassador Program has begun. More than 30 physicians, chaplains, nurses, social workers, multicultural representatives and other volunteers have been trained to spread the message within diverse communities through public speaking in seminars, conferences and other educational events.

Read more about Honoring Choices at www.honoringchoices.org and www.metrodoctors.com.

Preventing Opioid Overdose with Naloxone[1]



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

Opioid overdose is a major public health problem, accounting for almost 17,000 deaths a year in the United States.[2] Overdose involves both males and females of all ages, ethnicities, and demographic and economic characteristics, and involves both illicit opioids such as heroin and, increasingly, prescription opioid analgesics such as oxycodone, hydrocodone, fentanyl, and methadone.[3]

Physicians and other health care providers can make a major contribution toward reducing the toll of opioid overdose through the care they take in prescribing opioid analgesics and monitoring a patient's response, as well as through their acuity in identifying and effectively treating opioid overdose.

Effectiveness of Naloxone

Opioid overdose-related deaths can be prevented when naloxone is administered in a timely manner. As an opioid antagonist, naloxone displaces opiates from, and competes for, opioid receptor sites in the brain and prevents or reverses respiratory depression that usually is the cause of overdose deaths.[4] During the period of time when an overdose can become fatal, respiratory depression can be reversed by giving the individual naloxone.[5]

Opioid overdose is a major public health problem, accounting for almost 17,000 deaths a year in the United States.

On the other hand, naloxone is not effective in treating overdoses of barbiturates clonidine, tricyclic antidepressants, GHB, or ketamine. It also is not effective in overdoses with stimulants, such as cocaine and amphetamines (including methamphetamine and Ecstasy). However, if opioids are taken in combination with other sedatives or stimulants, naloxone may be helpful. Naloxone injection has been approved by the FDA and used for more than 40 years by emergency medical services (EMS) personnel to reverse opioid overdose and resuscitate persons who otherwise might have died in the absence of treatment.[6]

Naloxone has no psychoactive effects and does not present any potential for abuse.[7] Injectable naloxone is relatively inexpensive. It typically is supplied as a kit with two syringes, at a cost of about $6 per dose and $15 per kit.[8] These kits require training on how to administer naloxone using a syringe. The FDA has also approved a naloxone automated injector, called Evzio® which does not require special training to use because it has verbal instructions which are activated when the cap is removed from the device. This auto injector can deliver a dose of naloxone through clothing when placed on the outer thigh muscle. The per-dose cost of naloxone via the auto injector is not yet determined. For these reasons, it is important to determine whether local EMS personnel or other first responders have been trained to care for overdose, and whether they are allowed to stock naloxone in their drug kits.

Prescribing Naloxone

With proper education, patients on long-term opioid therapy and others at risk for overdose may benefit from having a naloxone kit containing naloxone, syringes, and needles or prescribing Evzio® which delivers a single dose of naloxone via a hand-held auto-injector that can be carried in a pocket or stored in a medicine cabinet to use in the event of known or suspected overdose.[9]

Patients at risk who are candidates for Naloxone

Those:

- Taking high doses of opioids for long-term management of chronic malignant or non-malignant pain
- Receiving rotating opioid medication regimens (and thus are at risk for incomplete cross-tolerance)
- Discharged from emergency medical care following

opioid intoxication or poisoning
- At high risk for overdose because of a legitimate medical need for analgesia, coupled with a suspected or confirmed history of substance abuse, dependence, or non-medical use of prescription or illicit opioids
- On certain opioid preparations that may increase the risk for opioid overdose such as extended release/long-acting preparations
- Completing mandatory opioid detoxification or abstinence programs
- Recently released from incarceration and a past user or abuser of opioids (and presumably with reduced opioid tolerance and high risk of relapse to opioid use)

It also may be advisable to suggest that the at-risk patient create an "overdose plan" to share with friends, partners, and/or caregivers. Such a plan would contain information on the signs of overdose and how to administer naloxone (e.g.: using an FDA-approved preparation of naloxone, a naloxone auto injector, or other FDA approved devices as they become available) or otherwise provide emergency care (as by calling 911).

Health care professionals who are concerned about legal risks associated with prescribing naloxone may be reassured by the fact that prescribing naloxone to manage opioid overdose 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. State laws and regulations generally prohibit physicians from prescribing a drug such as naloxone to a third party, such as a caregiver. (Illinois, Massachusetts, New York, and Washington are the four states with exceptions to this general principle.) More information on state policies is available at *http://www.prescribetoprevent.org/* or from individual state medical boards.

1) *Substance Abuse and Mental Health Services Administration. SAMHSA Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA) 14-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.*
2) *Centers for Disease Control and Prevention (CDC). CDC grand rounds: Prescription drug overdoses — A U.S. epidemic. MMWR Morb Mortal Wkly Rep.2012; 61(1):10-13.*
3) *Harvard Medical School. Painkillers fuel growth in drug addiction: Opioidoverdoses now kill more people than cocaine or heroin. Harvard Ment HlthLet. 2011; 27(7):4-5.*
4) *Enteen L, Bauer J, McLean R, Wheeler E, Huriaux E, Kral AH, BambergerJD. Overdose prevention and naloxone prescription for opioid users in SanFrancisco. J Urban Health. 2010 Dec; 87(6):931-941.*
5) *http://www.bmj.com]BMJ Evidence Centre. Treatment of opioid overdose with naloxone. BritishMedical Journal. Updated October 23, 2012. [Accessed March 24, 2013, at http://www.bmj.com]*
6) *Seal KH, Thawley R, Gee L et al. Naloxone distribution and cardiopulmonaryresuscitation training for injection drug users to prevent heroin overdosedeath: A pilot intervention study. J Urban Health. 2005; 82(2):303-311.*
7) *http://www.bmj.com]BMJ Evidence Centre. Treatment of opioid overdose with naloxone. BritishMedical Journal. Updated October 23, 2012. [Accessed March 24, 2013, at http://www.bmj.com]*
8) *Coffin PO, Sullivan SD. Cost effectiveness of distributing naloxone to heroinusers for lay overdose reversal. Ann Intl Med. 2013; 158:1-9.*
9) *http://www.bmj.com]BMJ Evidence Centre. Treatment of opioid overdose with naloxone. BritishMedical Journal. Updated October 23, 2012. [Accessed March 24, 2013, at http://www.bmj.com]*

Women's Way Expands Program Eligibility

Women's Way provides a way to pay for breast and cervical cancer screening and diagnostic follow-up for low income women who are underinsured or uninsured. *Women's Way* has been available for women between the ages of 40 through 64, but there has been a gap in coverage for younger women who are in need of preventative services but cannot afford to pay. To close this gap, *Women's Way* announces the expansion of program eligibility for women 21 to 39 years of age who meet the following specific eligibility requirements:

Barbara Steiner
Women's Way Clinical Coordinator
Nurse Consultant

A woman ages 21 to 39 can be enrolled in *Women's Way* if she:

- Is low income up to 200 percent of federal poverty level, and is uninsured or underinsured (health insurance does not fully cover screening services or diagnostic services) and
- Is symptomatic for a breast abnormality (includes a breast abnormality self-reported by a woman or a health-care provider-documented abnormality) or
- Is due for a Pap test according to the current United States Preventative Services Task Force (USPSTF) Cervical Cancer Screening Guidelines (has not had a Pap test within the last three to five years) or
- Is in need of a breast or cervical diagnostic procedure

Eligible women ages 21 to 39 can receive:

- Clinical breast exam to determine if there is a breast abnormality
- Mammogram or breast ultrasound, only if a breast abnormality is found and documented by a health-care provider during a clinical breast exam; abnormalities include a palpable lump, bloody discharge, nipple inversion, ulceration, dimpling or inflammation of the skin
- Pap test, if due or past due for screening, as indicated in the USPSTF Cervical Cancer Screening Guidelines for this age group
- Pap test as a follow-up to a previous abnormal result
- HPV test (women ages 21 to 29) only if the woman has had a documented abnormal Pap test and HPV test is indicated according to the American Society for Colposcopy and Cervical Pathology (ASCCP) guidelines
- HPV test (women ages 30 to 39) as part of co-testing along with Pap test or if needed due to an abnormal Pap test result
- Breast and/or cervical diagnostic services

Eligible women ages 40 to 64 can receive:

- Annual clinical breast exam and mammogram
- Conventional or Liquid-Based Pap test every three years with Pap test alone or every five years with combination of Pap test and HPV test for women who want to lengthen the screening interval
- Breast and/or cervical diagnostic or consultation services

Call the *Women's Way* local coordinator at 1-800-449-6636 for eligibility determination and enrollment.

If you are unable to reach the local coordinator, please call 1-800-280-5512 or 701-328-2306 to reach the *Women's Way* state office. Information is also available online at the *Women's Way* website – *www.ndhealth.gov/womensway.*

Women who report an income of 138 percent or less may be eligible to enroll in either Medicaid Expansion or Traditional Medicaid, both of which cover essential health benefits. These women can be referred to their local county social services office.

NORTH DAKOTA DEPARTMENT of HEALTH

Under Pressure

How to avoid breakdowns in high-stakes communications

LORI ATKINSON, RN, BSN, CPHRM
Manager, Education
MMIC Patient Safety Solutions

Consider these actual scenarios from our claim files:

Nursing staff failed to communicate its concern over a fetal heart rate pattern due to their past experience with a physician who "had a way of making nurses feel stupid" and often ignored their reports. The baby was born with severe neurological deficits and requires lifelong medical care.

A family physician and surgeon failed to communicate with each other about a patient's follow-up care, resulting in a delay in diagnosis of the patient's bone infection. The patient required multiple extensive surgeries.

An emergency department physician failed to communicate about a discharged patient's pending lab result when transferring care back to a skilled nursing facility. The lab report came back critically abnormal but no one followed up, and the patient died.

"What we have here is failure to communicate"

These scenarios illustrate how patients can suffer serious injury or death due to breakdowns in communication among the health care team. Breakdowns in communication can occur in a variety of ways, due to multiple factors. Frequent allegations include failure to report:

- A change in a patient's condition to the physician
- A pending test result at discharge
- A surgical complication to the covering provider during sign-out
- An accurate list of medications at transition of care

Factors causing such communication breakdowns can be attributed to:

- Absent teamwork skills training
- Unfamiliarity with each other's processes
- Hierarchical, disruptive culture
- Fast-paced, high-stress work environment
- Lack of standardized communication processes and tools
- Multiple providers, complex medical conditions and poor care coordination
- Unreliable medication reconciliation processes at transitions of care
- Documentation deficiencies

Transitions of care

Breakdowns in communication at transitions of care and poor care coordination are common causes of patient injury and often lead to hospital readmission. Many of these injuries are due to a failure in communicating significant patient information, including what medications the patient should be taking, outstanding lab results, and necessary follow-up care. Without formal processes and tools for communicating across the continuum of care, information can fall through the cracks, leading to errors and injuries.

A 2001 report from the Institute of Medicine – "Crossing the Chasm: A New Health Care System for the 21st Century"[1] – called for increased coordination across the continuum of care to improve quality of care and reduce errors.

Many physicians and hospitals now participate with the Centers for Medicare & Medicaid Services' (CMS) Partnership for Patients. The campaign's goals center on improving care transitions.

CMS hopes that by partnering with physicians, hospitals, and patients, preventable complications during transition of care will be decreased, with the goal of reducing hospital readmissions by 20 percent (compared to 2010). Achieving this goal would translate to more than 1.6 million patients recovering from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge. To support this effort, many hospitals now employ case management teams empowered to coordinate

post-hospital care, perform medication reconciliation, and arrange prompt follow-up care.

CMS recently revised its guidelines for hospitals around discharge planning.[2] The new guidelines recommend that a discharge plan be developed early in a patient's hospitalization based on an assessment of the patient's post-acute care needs. The hospital is thus responsible for implementation of the discharge plan, arranging transfer, and providing information to the next care provider. The new guidelines also include a bulleted list of medical information that the hospital must provide to the next care provider.

Hospitalists

The introduction of hospital-based physicians – i.e., hospitalists – who manage in-patient care, versus primary care physicians, has increased the number of transitions of care for patients. This subsequently increases the risk of communication failures leading to medical error and patient injury. The hospitalist model provides a coordinated approach to in-patient hospital care, but it also adds another layer of complexity to communication.

Primary care physicians have expressed concern about a lack of communication from hospitalists concerning their patients' courses of treatment, especially medication management. However, finding a mechanism for communication that fits the needs of both the hospitalist and primary care physician can be difficult; telephone calls are not always convenient for either party.

In one study, 77 percent of primary care physicians were aware of their patient being admitted to a hospital, but only 23 percent received direct communication from the hospitalist.[3] In addition, only 42 percent of primary care physicians reported being sent a discharge summary within two weeks of discharge.

One possible solution: auto-faxing and HIPAA compliant emails are now being used by many hospitalists to communicate information to primary care physicians. Health information technology (HIT) may also help facilitate the sharing of discharge checklists, summaries, and up-to-date medication lists.

High-risk areas

The specialty areas of obstetrics, surgery, and emergency medicine are high-stake zones for breakdowns in communication. When communication fails in these areas, resultant patient injuries can be catastrophic.

OBSTETRICS

Frequent malpractice allegations involved in adverse obstetrical events include:

- Failure to recognize and communicate abnormal fetal heart rate tracing
- Inappropriate use and management of high-risk medications, such as oxytocin
- Failure to adopt evidence-based standards
- Improper performance of operative vaginal delivery, primarily shoulder dystocia

Significant factors contributing to adverse obstetrical events and malpractice claims include:

- Communication breakdowns
- Lack of teamwork
- Culture that inhibits open communication
- Inconsistent practices, such as choosing personally preferred treatment plans rather than evidence-based protocols
- Documentation deficiencies

According to CRICO Strategies, miscommunication among the health care team contributes to 36 percent of claims, and documentation deficiencies to 26 percent of claims.[4] Researchers agree that formal training in teamwork skills and communication techniques is essential to decreasing risks associated with obstetric care.[5]

SURGERY

According to a report by CRICO Strategies (part of Controlled Risk Insurance Company), most surgical claims are preceded by cascading issues that span the entire operative process.[6] "Patients are at risk of (preventable) harm from the very decision to undergo a procedure through their post-op recovery at home," the

Primary care physicians have expressed concern about a lack of communication from hospitalists concerning their patients' courses of treatment, especially medication management. However, finding a mechanism for communication that fits the needs of both the hospitalist and primary care physician can be difficult; telephone calls are not always convenient for either party.

report states. The top three surgical services most vulnerable to patient injury and malpractice claims are:

- Orthopedics
- Neurosurgery
- General surgery

Failed communication handoffs among the health care team are a frequent root cause of surgical patient injury. Wrong-site, wrong-procedure, or wrong-person surgery claims are also often the result of faulty communication, and patients are particularly vulnerable to adverse events during the post-operative period.

Most surgical patients spend little time in the hospital; the majority of their recovery occurs at home or in a post-acute care setting. Thus, clear communication of recovery expectations with the patient, caregivers and post acute care team is essential.

EMERGENCY MEDICINE

The unique nature of the emergency department (ED) lends itself to increased risks for communication failures. Risk factors include:

- Unpredictable patient load
- Severity of patient conditions
- Noisy environment
- Multitasking requirements of physicians and staff
- Multiple providers and multiple teams of caregivers
- Multiple transitions of care at shift change and patient discharge

The most frequent allegations of patient injury in emergency medicine are:

- Diagnosis errors
- Improper treatment
- Medication errors

Teamwork and effective communication are crucial in the ED. In one study, communication failure was the lead contributing factor (35 percent of cases) in missed diagnoses, which frequently involved multiple breakdowns, contributing factors, and contributing clinicians.[7]

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

Keys to Patient Safety

The keys to patient safety and adverse event reduction are:

- Improved teamwork and communication
- Reliable care processes
- Superior documentation

MMIC Patient Safety Solutions consultants are your partners in patient safety. We can help you reach your patient safety goals by providing expertise and resources to implement the following recommendations:

1. **Assess your organization's patient safety culture** by surveying providers and staff using the Agency for Healthcare Research and Quality's (AHRQ's) Surveys on Patient Safety Culture: http://www.ahrq.gov/legacy/qual/patientsafetyculture/

2. **Provide teamwork skills training.** TeamSTEPPS is an evidence-based teamwork system that improves communication and teamwork skills among health care professionals. It was developed by the U.S. Department of Defense's Patient Safety Program, in collaboration with AHRQ: http://teamstepps.ahrq.gov/

3. **Use standardized communication processes** and tools for handoffs and transitions of care (e.g., SBAR — situation, background, assessment and recommendation)

4. **Establish routine team "huddles"** for cross-communication and verification of accountability

5. **Offer interdisciplinary education and training** on communication tools and care processes

6. **Utilize transfer forms and checklists** to ensure information shared at transitions of care is complete and consistent

7. **Implement a critical test result process** and communication procedure

8. **Ensure accurate and complete reconciliation** of medications across the continuum of care by utilizing a reliable medication reconciliation process and worksheet

9. **Practice emergency drills** and simulation training to enhance team communication in urgent and emergent situations

10. **Utilize health information technology** to augment clinical decision-making, enhance communication, improve medication reconciliation, and support documentation standards.

References

1. *Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. 2001. Available at www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx*
2. *CMS Revision to State Operations Manual (SOM), Hospital Appendix A - Interpretive Guidelines for 42 CFR 482.43, Discharge Planning. Available at www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-32.pdf*
3. *Bell CM, Schnipper JL, Auerback AD, et al. Association of communication between hospital-based physicians and primary care providers with patient outcomes. J Gen Intern Med. 2009;24(3):381-386.*
4. *CRICO Strategies 2010 Annual Benchmarking Report. Malpractice Risk in Obstetrics. Available at www.rmfstrategies.com/Products-and-Services/Comparative-Data/~/link.aspx?_id=7624374BFCD74E3FB53635710462CA7C&_z=z*
5. *Harris KT, Treanor CM, Salisbury ML. Improving patient safety with team coordination: challenges and strategies of implementation. JOGNN. 2006; 35(4):557-566.*
6. *CRICO Strategies 2009 Annual Benchmarking Report. Malpractice Risks in Surgery available at www.rmfstrategies.com/Products-and-Services/Comparative-Data/~/link.aspx?_id=7624374BFCD74E3FB53635710462CA7C&_z=z*
7. *Kachalia A. Gandi TK, Puopolo AL. Missed and Delayed Diagnoses in the Emergency Department: A Study of Closed Malpractice Claims From 4 Liability Insurers. Annals of Emergency Medicine. February 2007;49(2):196-205.*

Resources

The Centers for Medicare & Medicaid Services (CMS) Partnership for Patients: partnershipforpatients.cms.gov/

CRICO Clinician Resources: www.rmf.harvard.edu/Clinician-Resources

Institute for Healthcare Improvement (IHI) — Reduce Avoidable Hospital Readmissions: www.ihi.org/explore/Readmissions/Pages/default.aspx

IHI How-to Guides: Improving Transitions from the Hospital to the Clinical Office, Hospital to Community Settings, and Hospital to Skilled Nursing Facility to Reduce Avoidable Rehospitalizations: www.ihi.org/knowledge/Pages/HowtoImprove/default.aspx

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

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

MMIC

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

2015 Events Calendar

January 6, 2015

64th North Dakota Legislative Assembly begins
North Dakota State Capitol Building
Bismarck, ND

January 8-10, 2015

AMA State Legislative Strategy Conference
The Roosevelt Hotel
New Orleans, LA

January 19-23, 2015

38th Annual Family Medicine Update:
Big Sky Conference 2015
Big Sky Resort
Big Sky, MT

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

January 20-21, 2015

Legislative Health Screenings at the Capitol, provided by Dr. Brosseau and the Altru Staff
North Dakota State Capitol Building
Bismarck, ND

February 23, 2015

Hospital, Physician, and EMS Day at the Capitol
North Dakota State Capitol Building
Bismarck, ND

February 23-25, 2015

AMA National Advocacy Conference
Washington, D.C.

April 25, 2015

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

May 1-2, 2015

North Dakota and South Dakota Chapter of the American College of Surgeons 2015 Annual Meeting
Cambria Suites
West Fargo, ND

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

June 2-4, 2015

Dakota Conference on Rural and Public Health
Minot, ND

Contact Kylie Nissen at 701-777-5380 for information

June 6-10, 2015

AMA Annual Meeting
Hyatt Regency Hotel
Chicago, IL

August 21-22, 2015

North Dakota Society of Obstetrics and Gynecology
Community Center
Medora, ND

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

September or October

2015:NDMA Annual Meeting
Bismarck, ND

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