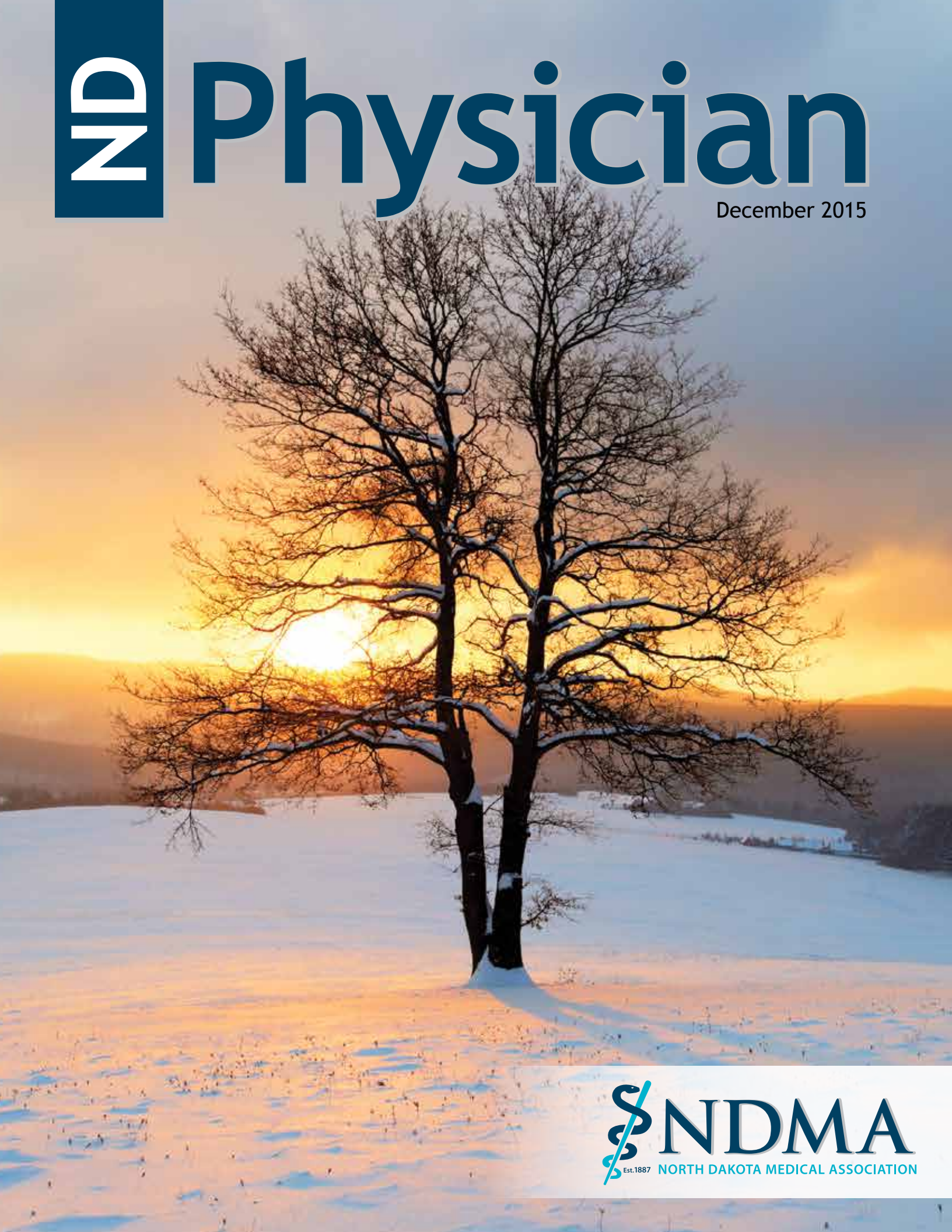
ND Physician

December 2015



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ND Physician

North Dakota Medical Association

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

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

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Katie Fitzsimmons, Editor

In this Issue

Physician Advocate

Facing Challenges in Medicine Today

Writing the President's message for the North Dakota Medical Association is an undertaking that always seemed very far off in the future. Indeed, eight years ago, when I received a phone call from Kim Krohn, MD, asking if I would serve NDMA as an officer, it seemed like a journey I never fully believed I would undertake. At that stage in my career, I had not fully learned how to say the word "no" and so here I am assuming the role of president of NDMA.

I take comfort in the fact that I have a lot of help. My predecessor, Steven Strinden, MD, has been an exceptional role model. I have been watching and learning from him each year as we transition from one officer position to the next. Steve's strongly principled and deliberate approach has helped navigate the association during some exceedingly difficult times. He will continue to be a strong guide for NDMA for years to come. Don't plan on going far, Steve! I have your cell number, email, I know where you work, and I can find where you live...

"Tho' they be but little, they are fierce". This is the way I would describe our small but tremendously effective NDMA staff. Katie, Annette, Leann, and Courtney are extremely knowledgeable, accessible, and simply a pleasure to work with. They truly carry the load of the association doing an amazing job for you on a day to day basis. Thanks in advance for years to come!

I appreciate the opportunity to serve as your NDMA president. I assume this role with the sincere intents to listen, to observe, and to ask questions. My only qualification to be your NDMA president is that I truly love North Dakota. I have lived here my entire life. When I travel I typically find myself wanting to come back. I have trained or worked in many locations within our great state – Grand Forks, Hettinger, Bismarck, Minot, Fargo, Carrington, and currently Jamestown. In every location I have found dedicated and knowledgeable physicians who understand our region's values and diversity. You have made North Dakota a national leader in providing high quality, low cost healthcare. With your help, and through NDMA, I look forward to ensuring that the healthcare services North Dakotans deserve continue and improve for future generations.

Our challenges are great. Everywhere we turn, someone is telling us the healthcare system is broken, healthcare is in crisis, healthcare is undergoing a massive transformation, or providing opinions on how to design the health system of the future. I would argue that the future is already here. Imagine robots performing surgery. Imagine GoogleGlass providing real-time support during trauma codes. Imagine research being done on a patient's fully genome sequenced avatar rather than on their own body. The public is expecting increased access to technology and the latest medical advances while health systems and payors are saying 'provide all this at a low cost please.' As William Gibson said, "the future is already here, it is just unevenly distributed."

To truly usher in the Golden Age of Medicine, we need to be equally or more poised to function as effective team members.

Debra Geier, MD, NDMA President

Is there no limit to what we can accomplish if it doesn't matter who gets the credit?

Our challenges span a variety of issues. Not only with how to manage technology, but also with how to manage scope of practice, governmental, and payment issues. These issues cannot be solved without the involvement of physicians – not only as leaders but also as team members. During my inaugural presidential address at our Annual Meeting, I asked the question: Is there no limit to what we can accomplish if it doesn't matter who gets the credit? Physicians are needed in all roles and capacities. We as physicians are much more accustomed to hearing about leadership and how physicians are poised to function as leaders. To truly usher in the Golden Age of Medicine, we need to be equally or more poised to function as effective team members.

Our true challenge is to accept new roles and grow the concept of team like never before. NDMA has been providing leadership to the medical community, building teams, and leading teams since 1887. Uniting with NDMA, North Dakota's physicians can effectively and positively impact the health and well-being of all North Dakotans.

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.

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NDMA in Action

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The 2015 Annual Meeting and Impact of NDMA Membership

Courtney M. Koebele, JD

The 2015 House of Delegates (HOD) is in the books and was well-received by those who attended. This issue of the *ND Physician* is dedicated to the annual meeting and focuses on its highlights and goals established.

Two very important issues were addressed by resolutions adopted by this year's HOD:

Prior Authorizations

President Debra Geier brought this issue to the attention of the House of Delegates. Precious time is taken away from caring for patients by dealing with multiple levels of prior authorization forms for every different drug and every different insurance company. This resolution, reviewed and introduced by the Council, calls for NDMA to work with other stakeholders to find a solution that works for all providers and payors. NDMA is putting together a group of stakeholders that will be meeting over the course of this year to begin an in-depth discussion of the issue and potential solutions.

Colorectal Cancer (CRC) screening

CRC is the third most commonly diagnosed cancer in North Dakota, third in deaths among all cancers in North Dakota, and North Dakota is in the highest quartile among states for CRC incidence. "80% by 2018" is a movement started by the National CRC Roundtable, in which dozens of organizations have committed to eliminating colorectal cancer as a major public health problem and are working toward the shared goal of reaching 80% screened for colorectal cancer by 2018. Led by NDMA vice-president Fadel Nammour, this resolution was adopted and NDMA will participate in this coalition. The goal of the group can be attained in part by communication to educate, empower, and mobilize three key unscreened audiences: 1) the newly insured; 2) the insured, procrastinator/rationalizer; and 3) the financially challenged. The next step is NDMA's collaboration with other interested groups to develop a unified statewide messaging on colorectal cancer screening. NDMA looks forward to working with partners, members and the community on this important public health issue.

NDMA membership gives physicians a unified voice in North Dakota and in Washington on critical issues such as Medicare reform, scope of practice, and improvement of public health.

NDMA Membership

The only way we can continue the great work of representing physicians is to have members. If you're reading this column, chances are you are a member. No one group or clinic or specialty can emphasize the common values and goals that physicians have as well as all physicians, collectively, together, as NDMA is the *only* association in the state that represents all of the state's physicians, residents, and medical students.

NDMA ensures that physicians' voices are heard

Whether it's a legislative hearing, a state agency meeting, or a topical discussion group, NDMA reinforces the importance of the physician/patient relationship and a fair and equitable reimbursement system.

NDMA monitors national issues for local impact

Equally important is NDMA's work with our Congressional delegation. In meetings in Washington, DC, and here in North Dakota, NDMA underscores the importance of retaining the Frontier Amendment and developing a long-term solution to the physician payment system.

NDMA provides a forum for physician involvement

NDMA's physician leaders gain a broader understanding of the opportunities and challenges

It is imperative that NDMA build strong physician leadership dedicated to cultivating a deep and broad representation of physicians throughout our state.

facing medicine today. Our team monitors emerging issues, shapes legislative proposals, and benefits from opportunities to build leadership skills, both in-state and at the national level. NDMA membership gives physicians a unified voice in North Dakota and in Washington on critical issues such as Medicare reform, scope of practice, and improvement of public health.

NDMA works on important public health issues

NDMA works in collaboration with the state health officer and in important coalitions to improve public health and raise awareness of public health issues, including tobacco use, immunizations, and violence prevention.

In looking to the future, it is imperative that NDMA build strong physician leadership dedicated to cultivating a deep and broad representation of physicians throughout our state. It is through this strength of leadership and diversity that NDMA can claim legitimacy in speaking for both physicians and their patients.

NDMA needs you to encourage your fellow physicians to join NDMA and to encourage our existing members to become more involved in Association activities, at both the district and state level. NDMA assumes a leadership role in all aspects of health care issues on the state and federal level. We need to ensure that the future strength and legitimacy of our message is clear.

NDMA assumes a leadership role in all aspects of health care issues on the state and federal level. We need to ensure that the future strength and legitimacy of our message is clear.

If we continue to show that NDMA provides value to physicians, NDMA can remain a robust organization, expertly serving the needs of North Dakota's physicians and patients. As you and your fellow physicians face new challenges, we would love to hear from you. We are here to represent you and support you. Thank you for your continued membership and participation.

Significant and Continuous Progress

News from the Dean of the UND SMHS

2015 has been a productive year for the UND School of Medicine and Health Sciences. Over the last year, the School—thanks to its faculty, staff, and especially students—has made significant progress in addressing each of its core purposes of education, research and scholarship, and service.

On the education front, I am pleased to report that the several additional residency slots recommended by the SMHS Advisory Council were approved by the SMHS. As you may recall, these positions have been funded through generous state appropriations authorized by the North Dakota Legislature. The new residency slots will be implemented as soon as they can be appropriately configured by the sponsoring institutions and, where needed, receive accreditation approval from the appropriate accrediting body. The newly approved residencies include the following:

- Two one-year geriatrics training slots in conjunction with Sanford Health and through our Department of Geriatrics
- An additional psychiatry residency slot with an emphasis on telepsychiatry through our Department of Psychiatry and Behavioral Science
- Five residency slots per year (three-year program) for a new family medicine program in Fargo, based at Sanford Health and with collaborative arrangements with Essentia Health in Fargo and various rural communities in the state

The SMHS Advisory Council also recommended funding for the Western North Dakota Area Health Education Center (AHEC) to complete Phase II of a study exploring ways to expand health student education in rural communities in North Dakota.

I am delighted to report that the School is joining an elite consortium of other medical schools, including the Mayo Medical School, the University of Michigan Medical School, and Harvard Medical School, as part of the American Medical Association's (AMA) Accelerating Change in Medical Education Consortium. The consortium comprises a total of 31 schools that are working to create the medical school of the future. The AMA has awarded each consortium member a grant for transformative medical education projects in key innovation areas. Our grant was submitted by Senior Associate Dean Gwen W. Halaas in conjunction with Associate Dean for Teaching and Learning and the founding Dr. David and Lola Rognlie Monson Endowed Professor in Medical Education Rick Van Eck. They outlined our plan to enhance medical education through advanced simulation and telemedicine technologies to develop skills specific to the needs of rural or remote communities. The program that is being developed involves teams of interprofessional students and teaches interprofessional competencies along with rural healthcare skills.

The SMHS continues to grow its research enterprise. One objective measure of that growth is the amount of externally sponsored (typically federal) funding our investigators have garnered. And I'm delighted to report that researchers at the School were awarded this recently ended fiscal year the largest amount of funding in the history of the School! That growth was the principal reason that UND as a whole also showed growth in its total research funding after several years of overall decline. By the way, the School has achieved about a five percent annual growth in funding this decade, which is all the more impressive in this era of extremely tight and competitive funding. Even more important is that research publications are up, which is an even better measure of the new knowledge that our investigators have discovered. In the clinical departments, for example, publications are up nearly 50 percent compared with the prior year.

Joshua Wynne, MD, MBA, MPH

I am delighted to report that the School is joining an elite consortium of other medical schools, including the Mayo Medical School, the University of Michigan Medical School, and Harvard Medical School, as part of the American Medical Association's (AMA) Accelerating Change in Medical Education Consortium.

The School's most important service contribution is through its healthcare workforce development. Thanks to the Healthcare Workforce Initiative and funding provided by the North Dakota Legislature, the medical school class size is now the largest in history at 78 students per year. Similarly, the health sciences class sizes also are expanded and at their highest levels ever, as are our in-state residency opportunities. Having more in-state residency positions is crucial for our state, since we traditionally have had the lowest ratio of residency slots per graduating physician of any state in the country. What this means is that

before residency expansion about half the class had to leave North Dakota for residency training even if the entire class wanted to stay—there simply were not enough slots available. Nationally, there are about 1 residency slots (about 30,000) per medical school graduate (about 20,000) or a ratio of about 1.5 to 1; North Dakota had been around 0.5 to 1, or about a third of the national average.

The expanded training positions at the School for medical students, health sciences students, and to a limited degree the residency trainees required additional facility space, and as you know, we are completing the construction of a magnificent new building to house all of these expanded educational offerings. The new 325,000-square-foot building should be completed this coming July, just in time to welcome the entering medical student class of 2020. Not only is the building right on schedule but it is on budget as well. We are busily planning for the transition into the new space, for the move will entail both a physical as well as pedagogical transformation. By that I mean that we need to plan both for moving the people, equipment, and other tangible assets into the new facility, but we also need to plan for the new ways in which we will be educating students, with many more educational spaces that are intended to be multi- and interprofessional in their orientation and focus.

Thanks to the Healthcare Workforce Initiative and funding provided by the North Dakota Legislature, the medical school class size is now the largest in history at 78 students per year.

Finally, here is an update on the recent revisit to the school in October by a team from the Liaison Committee on Medical education (LCME). The team decided to shorten its visit from 2 1/2 days to 1 1/2 days after reviewing the Briefing Book that we had prepared for them. That seemed to be a good indication, as all felt that the revisit went quite well. While we won't hear the final word from the LCME until February or March of 2016, all who met with the survey team felt that the meetings went well. So we are hopeful that we will get positive affirmation from the LCME this spring. If all goes as anticipated, we will be back on schedule for our next LCME visit in 2022. To help ensure a painless and successful visit then, we are changing the way we prepare for these accreditation visits. Rather than starting our preparations about two years before the next visit, we've decided to start our preparations now. So we've instituted a process that is equivalent to the continuous quality improvement process that is used widely in the commercial and hospital arena—but in this case we'll do continuous LCME preparation. I've named Dr. Steve Tinguely, the prior chair of the Department of Pediatrics, as our first assistant dean of medical accreditation and chief medical accreditation officer. Steve will work with the School's faculty, staff, and students to address medical accreditation issues on an ongoing and consistent basis to ensure that the School addresses medical accreditation issues iteratively, consistently, and continuously. Most medical schools have not moved to this newer model for addressing accreditation and compliance issues, and I believe that we are again leading the nation in the approach that we are taking.

AMA Interim Meeting
November 2015, Atlanta, Georgia
A Report from our AMA Delegate


Shari Orser, MD, AMA Delegate

Alternate Delegate A. Michael Booth, MD, Vice-President Fadel Nammour, MD, NDMA executive director Courtney Koebele, and I attended the Annual Interim meeting in Atlanta on November 14 – 17, 2015.

Policies addressed at the meeting included:

Combat Antibiotic Resistance
This initiative supports adequate funding for public health and veterinary health agencies to improve surveillance of antimicrobial resistance and antibiotic use, which aligns with the administration's National Action Plan for Combating Antibiotic Resistant Bacteria. According to a report by the AMA's Council on Science and Public Health, improved surveillance will help identify where antibiotic resistant infections originate and how resistant bacteria are being transmitted.

Ensuring Access to Mental Health Care for Medical Students, Resident and Fellow Physicians
According to the American Foundation for Suicide Prevention, approximately 300 to 400 physicians die as a result of suicide in the United States each year and the rate of depression among medical students is 15 to 30 percent higher than the general population. In an effort to address this growing need, the AMA adopted policy aimed at ensuring medical students and resident and fellow physicians have access to potentially life-saving mental health services during their medical training.

A recent study in JAMA Psychiatry found that despite an increase in suicidal thoughts and mental health problems among resident physicians, very few actually seek mental health services—citing concerns about confidentiality as one of the main reasons. To help address this barrier to care, the AMA's new policy promotes confidential, accessible, and affordable mental health services for medical students and resident and fellow physicians.

Improving Access to Naloxone to Prevent Opioid Overdose and Save Lives
Building upon the AMA's efforts to combat opioid misuse and overdose, the AMA adopted policy to increase access to naloxone, a life-saving medication that can reverse the effects of an opioid overdose by restoring breathing and preventing death. According to the CDC, naloxone is responsible for saving the lives of more than 26,000 people in the U.S since 1996.

To help increase access to naloxone for patients at risk of overdose, as well as make naloxone more readily available to family members and close friends of those at increased risk of overdose, the new policy encourages manufacturers or other qualified sponsors to pursue the Food and Drug Administration's application process for approval of naloxone as an over the counter medication.

Secure Adequate Funding for Graduate Medical Education
The AMA renewed its support for securing alternative funding sources for graduate medical education (GME) to increase the number of medical residency slots needed to care for patients in today's health care system and to help address the national physician shortage.

Under the new policy, the organization will encourage insurance payers and foundations to enter into partnerships with state and local agencies, as well as academic medical centers and community hospitals, to expand GME funding. The policy also calls on organizations with successful GME funding models to share strategies, outcomes, and costs for implementation. Additionally, the AMA plans to increase public awareness of the importance of graduate medical education, student debt, and the state of the medical profession.

Ban on Direct-to-Consumer Advertising of Prescription Drugs and Medical Devices
Responding to the billions of advertising dollars being spent to promote prescription products, new policy was adopted aimed at driving solutions to make prescription drugs more affordable.

Physicians cited concerns that a growing proliferation of ads is driving demand for expensive treatments despite the clinical effectiveness of less costly alternatives.

The United States and New Zealand are the only two countries in the world that allow direct-to-consumer advertising of prescription drugs. Advertising dollars spent by drug makers have increased by 30 percent in the last two years to $4.5 billion, according to the market research firm Kantar Media.

This new policy responds to deepened concerns that anticompetitive behavior in a consolidated pharmaceutical marketplace has the potential to increase drug prices. The AMA will encourage actions by federal regulators to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.

Reduce Burdens of Meaningful Use Program

Recently, an AMA-led coalition of 111 medical societies called on Congressional leaders to refocus the Meaningful Use program on the goal of achieving a truly interoperable system of electronic health records.

This urgent call for action comes in the wake of the administration's decision to move ahead with implementation of Stage 3 of the Meaningful Use (MU) program despite widespread failure of Stage 2. In a string of letters to House and Senate leaders, the AMA and other medical societies noted that what has emerged from the administration is a "morass of regulation" for a program that has "failed to focus on interoperability and has instead created new barriers to easily exchange data and information across care settings."

The AMA adopted new policy that seeks revisions to quality standards and MU requirements to make them more streamlined, usable, and less burdensome. The AMA also adopted new policy that would enhance its efforts to accelerate the development and adoption of universal and enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of the Medicare Incentive Based Payment (MIPs).

Support for Veterans to Paramedics Transition Act of 2015

The AMA adopted policy calling for support of federal, bi-partisan legislation that would expedite and streamline paramedic training for returning veterans who have already received emergency medical training while in the military.

Introduced by US Senators Amy Klobuchar (D-MN) and Mike Enzi (R-WY), Senate Bill 218 would create the Veterans to Paramedics Transition Act of 2015—authorizing federal grants for universities, colleges, technical schools, and state EMS agencies to develop curricula that would help these veterans more quickly become eligible for paramedic certification.

Enhancing Electronic Tools to Prevent Prescription Opioid Abuse

Continuing efforts to combat the nation's opioid epidemic, the AMA adopted policy in support of developing model state legislation that will help further support the AMA's goal of increasing physician registration and use of state-based prescription drug monitoring programs (PDMP). The AMA strongly supports ensuring patient privacy protections, interstate interoperability of PDMPs, as well as improving the functionality and workflow of these tools to help physicians make informed prescribing decisions.

The policy adopted today also calls on the federal government to delay its MU program until real-time integration between EHRs and PDMPs is achieved and electronic prescribing of schedule II and III drugs is available for the country's MU certified EHRs.

Ensure Consumer Access to Health Care Amid Proposed Insurance Mergers

New policy passed during the AMA Interim Meeting calls on the federal government to examine health insurance industry consolidation in the US over the last 5 to 10 years before allowing further mergers of health insurance companies. This policy is aimed at strengthening its efforts to ensure consumers maintain access to quality, affordable health care in the insurance marketplace.

Dinner out in Atlanta. Clockwise from left: Tim Ridgway, MD, SDSMA president; A. Michael Booth, MD; Courtney Koebele; Dan Heinemann, MD; Herb Saloum, MD; Linda Saloum; Benjamin Meyer, medical student; Shari Orser, MD; Fadel Nammour, MD; Mary Carpenter, MD.

Colorectal Cancer: Developing a Unified Message in North Dakota


Katie Fitzsimmons

On November 18, NDMA's Vice President and Council Chair Dr. Fadel Nammour and I attended a meeting dedicated to enhancing resources and awareness surrounding colorectal cancer. The American Cancer Society and the Department of Health hosted and facilitated the meeting, which was fueled by the **80% by 2018 campaign by the National Colorectal Cancer Roundtable initiative**. The Roundtable's goal is to increase colorectal cancer screenings to include 80% of the at-risk population (50-64 year olds). If that goal is achieved, 277,000 cases and 203,000 colon cancer deaths would be prevented by 2030. Those numbers are truly astounding!

The discussion focused upon: which groups we need to target and how will we reach them. The main categories we worked on were the "unworried well"- those that feel they are healthy and therefore, do not feel that they need screenings or tests; Native Americans; the newly insured; the financially challenged; and the uninsured. We discussed advertising campaigns, PSAs, brochures, direct patient interventions, and other means of motivating these groups to get screened on some level, whether it is a colonoscopy, a home Fecal Immunochemoical Test (FIT), or Fecal Occult Blood Test (FOBT). Similar to starting a tobacco cessation endeavor, the chances of an individual getting screened rises significantly if a physician recommends such

Table 1

	Demographic Profile	Emotional Profile
Age	• More likely to be younger than those screened; **nearly two-thirds are 50-59 years of age**.	• Think they are taking care of their health already • Fearful of the unknown • Fearful of preparation/ procedure • Focused on more immediate health concerns • Procrastinators • Rationalize reasons for not being screened • Lack sense of urgency around the issue • Have an "I know best" attitude"
Insurance Status	• More likely to be **uninsured (nearly one-quarter)** than those screened.	
Income	• Slightly lower income than those screened, with **over one-half earning under $40K** per year.	
Race/ Ethnicity	• More likely to be Hispanic than those screened (nearly five in ten eligible Hispanics are not being screened).	
Education	• Slightly more likely (around seven in ten) to have less than a 4-year college degree than those who have been screened.	
Cancer Connection	• Less likely to be a cancer survivor (<7%) and less likely to have a close friend/family member with cancer than those screened (just over half).	

action to a patient. The graphics demonstrate what we are working with when it comes to why individuals do not get screened. Table 1 shows the demographic and emotional profile of those that need we need to reach to attain this important health screening. Table 2 shows the results of the study conducted by the Roundtable. Table 3 shows the likelihood that an individual would be screened if they were aware of specific information.

This will be an ongoing endeavor for NDMA and the stakeholders that are around the table. If you would like to become more involved, please contact our office for more information. We will keep you posted with happenings and developments.

Table 2

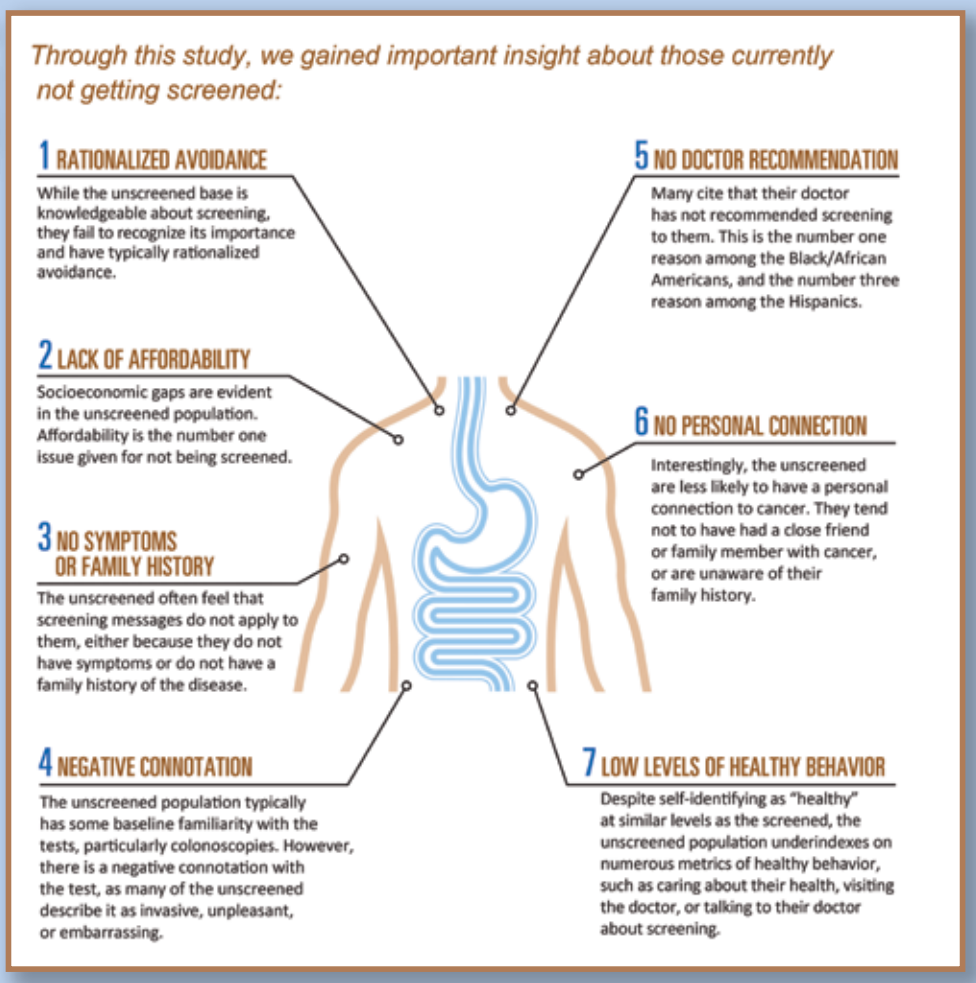
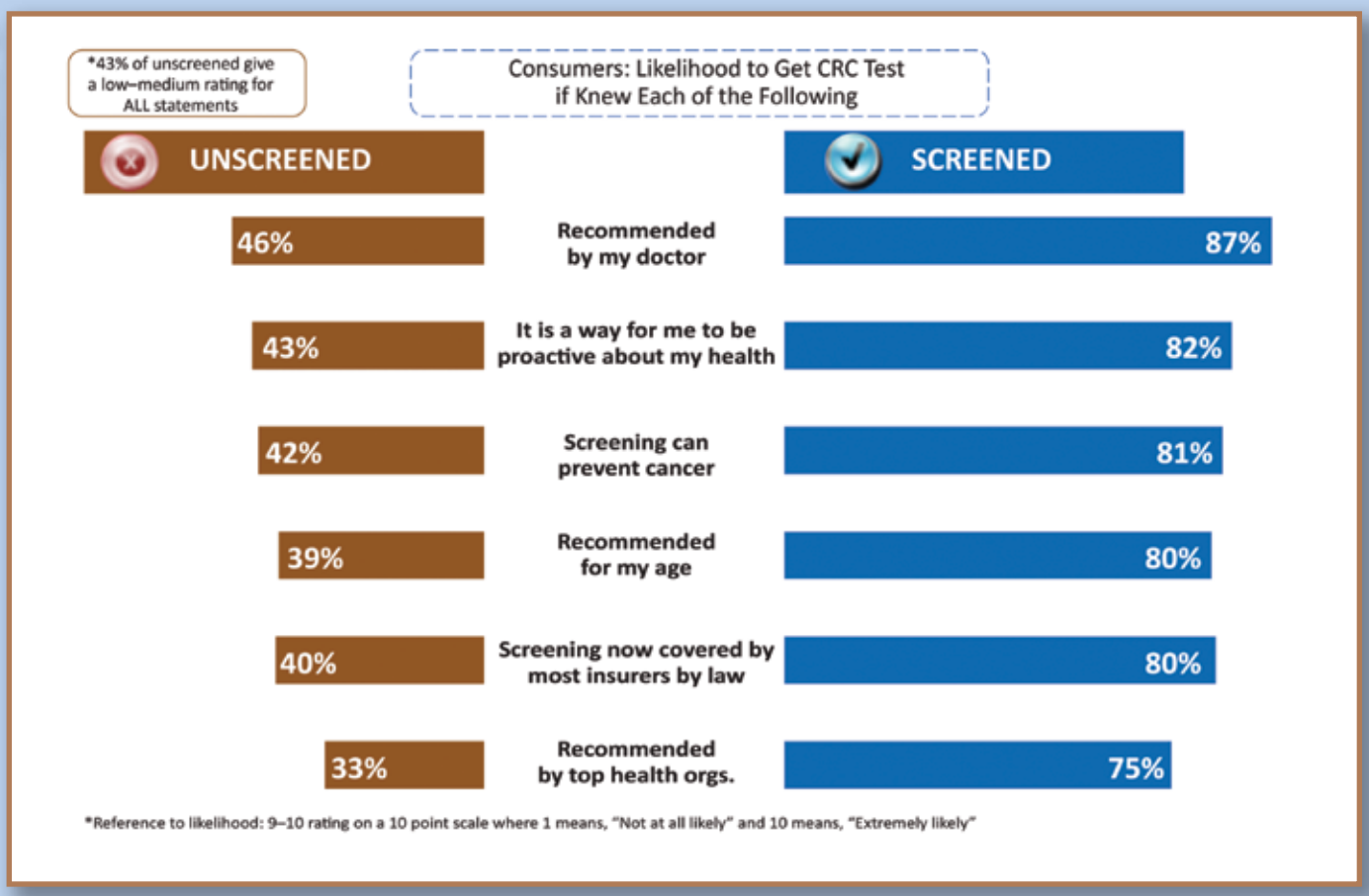


Table 3



About 80% by 2018

What is 80% by 2018?

"80% by 2018" is a National Colorectal Cancer Roundtable initiative in which dozens of organizations have committed to eliminating colorectal cancer as a major public health problem and are working toward the shared goal of reaching 80% of adults aged 50 and older screened for colorectal cancer by 2018.

The National Colorectal Cancer Roundtable, an organization co-founded by the American Cancer Society and the Centers for Disease Control and Prevention, is using this March, National Colorectal Cancer Awareness Month, to rally organizations behind this shared goal.

80% by 2018 Vision Statement:
Our organizations stand united in the belief that we can eliminate colorectal cancer as a major public health problem. We have screening technologies that work, the national capacity to apply these technologies, and effective local models for delivering the continuum of care in a more organized fashion. Equal access to care is everyone's responsibility. We share a commitment to eliminating disparities in access to care. As such, our organizations will work to empower communities, patients, providers, community health centers and health systems to embrace these models and develop the partnerships needed to deliver coordinated, quality colorectal cancer screening and follow up care that engages the patient and empowers them to complete needed care from screening through treatment and long-term follow-up.

Why are organizations committing to 80% by 2018?

80% by 2018 Talking Points

Colorectal cancer is a major public health problem.

- Colorectal cancer is the third leading cause of cancer death in men and women in the U.S., and a cause of considerable suffering among more than 140,000 adults diagnosed with colorectal cancer each year.
- When adults get screened for colorectal cancer, it can be detected early at a stage when treatment is most likely to be successful, and in some cases, it can be prevented through the detection and removal of precancerous polyps.
- About 1 in 3 adults between 50 and 75 years old – about 23 million people – are not getting tested as recommended.
- The people less likely to get tested are Hispanics, American Indians or Alaska Natives, rural populations, men, those 50 to 64, and those with lower education and income.
- Screening can save lives but only if people get tested.
- There are several recommended screening test options, including: colonoscopy, stool tests (guaiac fecal occult blood test [FOBT] or fecal immunochemical test [FIT]), and sigmoidoscopy.
- The best test is the one that gets done.

Our organizations stand united in the belief that we can eliminate colorectal cancer as a major public health problem.

- We know what we need to do to get more people screened for colorectal cancer, prevent more cancers and save lives.
- We share a commitment to eliminating disparities in access to care. Our organizations will work toward a common goal to empower communities, patients, health care providers, community health centers, and health systems to close the screening gap.
- Achieving an 80 percent screening rate by 2018 will require the collaboration of many leaders; it cannot be achieved working in isolation.
- Health care providers, health systems, communities, businesses, community health centers, government, and every day Americans all have a role to play.
- Dozens of groups, including the American Cancer Society, have pledged to work together to increase the nation's colon cancer screening rates and embrace the goal of reaching 80% screened for colorectal cancer by 2018.

Now is the time to work together to reach an 80 percent colorectal cancer screening rate by 2018

- The percentage of the population up-to-date with recommended colorectal cancer screening increased from 56 percent in 2002 to 65 percent in 20101.
- Still, patients and providers do not always know about or consider all the available recommended screening tests, and currently, most health care providers and systems are not set up to help more people get screened for colorectal cancer.
- Top health systems already are achieving 80% screening rates. Massachusetts is already screening over 76% of their eligible population, the highest screening rate in the nation. An 80% screening rate is achievable.
- Across our nation significant disparities exist but we are committed to eliminating these disparities. The healthcare landscape is changing and barriers for colorectal cancer screening are breaking down.
- Part of the 80 percent by 2018 goal is to leverage the energy of multiple and diverse committed partners to make history and achieve this remarkable public health goal.
- By working together, demanding more of ourselves, and collectively pushing harder toward this common goal, we will make greater progress, prevent more cancers, and save more lives than we would by acting alone.

1 Morbidity and Mortality Weekly Report: Vital Signs: Colorectal Cancer Screening Test Use — United States, 2012. Centers for Disease Control and Prevention. November 5, 2013. Vol. 62

What do I Need for Electronic Prescribing of Controlled Substances?

The Drug Enforcement Agency (DEA) issued a rule change in 2010 allowing for electronic prescribing of controlled substances.[1] North Dakota Administrative Code (NDAC) also allows for computer transmission of all prescriptions, including controlled substances in schedules II-V.[2] However, both require specific electronic signatures. These electronic signatures are obtained by the prescriber via application to the DEA. But that is not the only requirement for receiving and dispensing the controlled prescriptions. Pharmacies also have a responsibility to make sure their software is capable of monitoring the prescription, any changes made to it, and the verification of the prescriber's signature. All of this can be done by a third-party provider who will also perform annual audits of authorized prescribers to ensure that only those granted access to the system are doing so.[3] Thus, it is a process to ensure that all the appropriate bases are covered before allowing transmission of controlled substance prescriptions.

After electronic prescriptions for controlled substances are capable of being received, a pharmacy still maintains all the same responsibilities required of written or oral controlled substance prescriptions.

The prescriber will be using two-factor authentication. This is similar to an ATM's requirements. The individual trying to use the ATM needs to know an identification number and have a bank card in order to access any information.[4] The same will be true for transmitting a controlled substance prescription. This is to create a more secure network and avoid unauthorized individuals from accessing the system. The thought is, since there is no handwriting or verbal communication that may help identify if an imposter is present, this would help deter diversion instead.[4] To obtain both factors of the authentication, there is a process involving a credential service provider or a certification authority that meets specific requirements.[3]

After prescribers obtain authorization to send controlled substances via electronic prescription, the third-party provider audits them. The audit on authorized prescribers must be conducted annually by a qualified individual.[5] In this case, a qualified individual is one who would also be qualified to conduct specific audits such as SysTrust, WebTrust, or SAS 70 audit. This requirement may slow the process as they obtain these accreditations if they do not already have them. The third-party providers also look at the software of each pharmacy to make sure they meet all the requirements set forth to properly import, store, display the information, and verify prescribers.[3] Both of these are major steps and take time to process.

While the third-party provider is doing most of the work for the pharmacy to ensure that their software is capable and up to date, the pharmacy may set controls to limit access to prescription information so that it cannot be changed.[3] After electronic prescriptions for controlled substances are capable of being received, a pharmacy still maintains all the same responsibilities required of written or oral controlled substance prescriptions. This includes

Mikayla Fick, 2016 PharmD Candidate and Mark Hardy, Executive Director of the North Dakota Board of Pharmacy

making sure all information is present on the prescription and the medication is appropriate for the patient.[5]

Being able to utilize electronic prescribing for controlled substances is a process. There are many factors involved to ensure that the appropriate people have access to the system and that pharmacies have the ability to verify this information. A lot of the process relies on the individual prescriber and the third-party providers. However, pharmacies will still ultimately hold the key to insuring the right medication is reaching the right patient.

Currently, there are a few prescribers and pharmacies authorized to transmit and receive electronic controlled substance prescriptions in North Dakota. We envision many more being approved in the next year, which has prompted many questions to our office. As always, it is important to verify the integrity of a controlled substance prescription with the prescriber should there be any questions or concerns.

Should you have any questions, feel free to contact the North Dakota Board of Pharmacy office at 701-328-9535.

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4. Drug Enforcement Administration. 21 CFR Parts 1300, 1304, 1306, and 1311: Electronic Prescriptions for Controlled Substances; Final Rule. Federal Register: Part II. 2010 March 31;75(61): 16235-16319.
5. Rannazzisi JT. 21 CFR Parts 1300, 1304, 1306, and 1311 [Docket No. DEA-360]: Electronic Prescriptions for Controlled Substances Clarification. Office of Diversion Control; 2011 October 7;1-10.

Home First: an IPAT Resource

Trish Floyd and Peggy Shireley, IPAT AT Consultants

At Interagency Program for Assistive Technology (IPAT), we know that people experiencing the effects of aging and those with disabilities need to find different ways to do things. That is why we created the Home First Showroom in Fargo, the Home First Showroom app, and the Home First Showroom YouTube Channel.

Different ways to do things are often accomplished using assistive technology (AT), and we love to help people find the AT they need. For example, someone with arthritis may need to use a roll-about to get a pot of water to the stove, an individual with vision loss may need to place their mail under an electronic magnifier to read it independently, someone with a hearing impairment may need to use an amplified phone, or an individual with mobility loss may use an EZ-cane to climb stairs.

To help inform the people of North Dakota about the power of AT, IPAT created a unique Home First Showroom in Fargo in October of 2013. It consists of a "real home" environment with a kitchen, living room, bedroom, dining room, bathroom, and den. Each area boasts AT devices typical to that space which visitors are encouraged to try out. Unlike any other AT demonstration site in the nation, the Home First Showroom lets people use the devices in a home setting to see how they could work in the context of their own home. Anyone is welcome to call the Fargo office to set up a tour of the Home First Showroom.

For those unable to travel to Fargo, in June of 2014 IPAT released the IPAT's Home First Showroom app for iOS devices. This app provides an opportunity for anyone to visit the Showroom via a virtual tour. The app is free and can be downloaded through the App Store. Realizing that not everyone has access to an iOS device, we also created the IPAT's Home First Showroom YouTube Channel. It has all the same devices highlighted with a corresponding video describing device function, all just a click away! All the user needs is a computer or android device with access to the internet.

We invite you to explore Home First Showroom options in whichever mode fits you best. If these modes do not fit your needs, give IPAT a call at 800-895-4728.

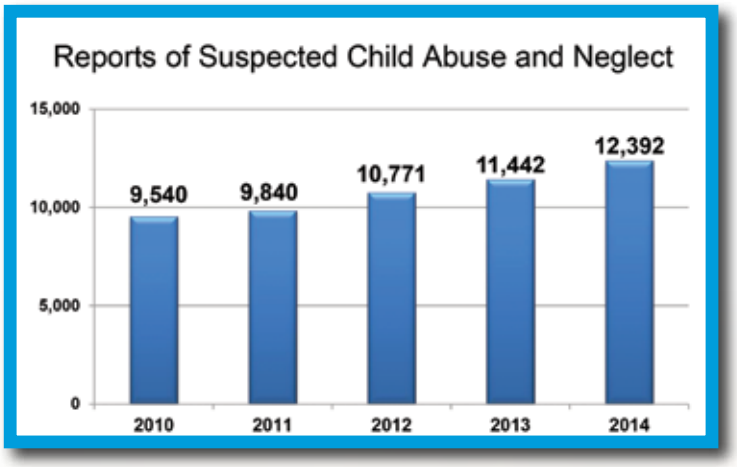
Physicians Can Help Child Abuse Victims

Learn how to recognize and report child abuse and neglect

Marlys Baker,
Child Protection Services Administrator
North Dakota Department of Human Services

Everyone should be concerned about protecting children. Physicians, nurses, and other medical professionals are among a select group of professionals (mandated reporters) required by North Dakota law to report suspected child abuse and neglect because of their roles in providing care to children and families.

Mandated reporters are often the only people outside the immediate family who might be in a position to identify suspected child abuse and neglect. They are a crucial link to the child protection system.



While anyone in North Dakota can report suspected child abuse or neglect, it is crucial to the safety of children that mandated reporters are knowledgeable about their reporting requirements and the process that is triggered after a report is made.

Recognizing

The first step in helping an abused or neglected child is understanding what defines child maltreatment and to recognize the signs.

There are two types of child maltreatment – abuse and neglect:

Abuse

- Physical Abuse - a caregiver uses physical force on a child that injury to the child occurs or could occur
- Sexual Abuse - an adult engages in any sexual behavior (looking, showing, or touching) with a child to meet the adult's interest or sexual needs. This includes the manufacture, distribution and viewing of child pornography. Sexual touching between children can also be sexual abuse when there is a significant age difference between the children or if the children are very different developmentally or in physical size

Neglect

- Physical neglect exists whenever a caregiver:
  - Fails to provide a child with adequate food, clothing, medical care, shelter, supervision, education, or financial support, when the caregiver has the financial means to provide for them
  - Endangers a child with unhealthy home conditions, environmental exposure to controlled substances, and prenatal exposure to controlled substances
  - Fails to protect the child from maltreatment by others and abandonment

- Psychological Maltreatment is a form of neglect with patterns of behavior or extreme incidents which involve rejecting, isolating, threatening, ignoring, and/or exposing to negative influences whether through acts of omission or commission

The Child Protection Services System uses definitions contained in state law to make determinations as to whether a child has been abused or neglected. This is a higher standard than what is required for reporting. For the purpose of making a report of suspected child abuse or neglect, the standard established in law is "reasonable cause to suspect" that a child may be abused or neglected. This is a "reasonable person standard" rather than a personal opinion.

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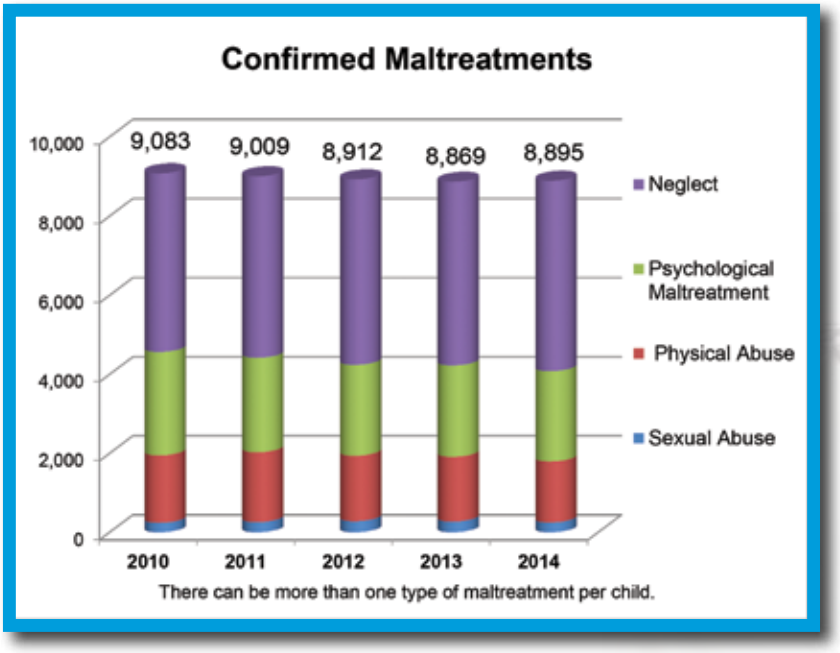
Reporting

In 2014, about 74 percent of all confirmed child abuse and neglect reports came from mandated reporters.



There were 1,668 confirmed victims of child abuse and neglect from all reporters.

A report must be made by a physician, nurse, or other medical professional, when in his or her official capacity, suspects or has reason to believe that a child has been abused or neglected. By law, a mandated reporter must immediately report any reasonable suspicion that a child may be abused or neglected. Reports are made to the county social service office in the county where the child is present at the time the report is made. Reporting to a supervisor or department head does not fulfill the legal requirement for a mandated reporter.

In 2014, about 74 percent of all confirmed child abuse and neglect reports came from mandated reporters. There were 1,668 confirmed victims of child abuse and neglect from all reporters.

Reports may be made orally, but a mandated reporter is required to provide a written report within 48 hours using State Form Number 960. Any photographs, imaging studies, laboratory tests, colposcopies, and other medical tests taken during a medical evaluation for child abuse or neglect must be provided to the county social service office upon request.

Did you Know?

Physicians have the authority to detain a child on medical hold for suspected child abuse and neglect.

ND Century Code 50-25.1-07. Protective Custody.

Legal Protections

Under North Dakota law, any person, other than the alleged violator, participating in good faith in the making of a report, assisting in an investigation or assessment, furnishing information, or in providing protective services is immune from civil or criminal liability. The law also states that reports must be presumed to be made in good faith. All reports of suspected child abuse and neglect are confidential, but there are some provisions in the law that allow for information to be shared.

Legal Penalties

It is a Class B Misdemeanor when:

- A mandated reporter willfully fails to make a report
- Anyone willfully makes a false report
- Confidential information is disclosed without authorization

Assessment

After a report is made to a county social service office, the report is analyzed to determine whether the concerns meet the requirements of state law. If so, a county social worker is assigned to conduct an assessment that includes risk, safety, and family strengths and need for services. They use a variety of methods to conduct an assessment including face-to-face interviews with children, parents, and others, and collecting of documentation from other agencies and individuals with knowledge of the child or family.

It is important that mandated reporters participate in the assessment process by providing evidence in the form of written documentation and verbal information. Physicians play a vital role in providing medical expertise to a social worker by interpreting medical records and test results and helping to define the impacts of injuries and conditions on a child.

Child Protection Services (CPS) must use legal definitions to establish a preponderance of evidence in order to confirm that a child was abused or neglected. Without active participation from a mandated reporter and medical experts, a child may remain unprotected if sufficient information cannot be gathered to provide evidence that a child is in need of services and protection.

Did you Know?

Physicians may receive confidential CPS information under certain circumstances.

ND Century Code 50-25.1-11. Code Confidentiality of Records - Authorized Disclosures.

Findings

After the assessment is complete, a decision of "Services Required" or "No Services Required" is made based on the evidence and the legal definitions of abuse and neglect.

- "Services Required" means that a child has been abused or neglected.
- "No Services Required" means the information in the assessment did not meet the legal definitions of abuse or neglect.

When a decision is made that services are required for the protection and treatment of an abused or neglected child, a county social service office assigns a case manager to work with the family and connect them to services to reduce or eliminate the risk of future maltreatment. Children may be placed in a licensed foster care setting if they are not safe in their own home.

A CPS worker does not have authority to remove a child from their home. Even in an emergency situation, a temporary custody order must be requested and granted by Juvenile Court and there must be a hearing within 96 hours to determine if continued removal is warranted. Law enforcement officers have the authority to remove a child in imminent danger without a court order. Medical personnel may need to testify to provide the Court with sufficient evidence to continue protective custody of a child.

If a "No Services Required" determination is made, referrals are offered to a family to help meet needs identified in the assessment. Counties may offer case management or other services to a family. When services are being provided, mandated reporters can play a role in supporting and encouraging family participation to prevent future maltreatment.

Mandated Reporter Training

This article just scratches the surface when it comes to child abuse and neglect laws. The North Dakota Department of Human Services created an interactive web-based training to help mandated reporters understand their reporting responsibilities. The training includes modules specifically designed for medical professionals on reporting, recognizing abuse and neglect, filing a report of suspected child abuse or neglect, and the law pertaining to abuse and neglect. It is available at no cost and takes about one hour to complete. The training is online at www.pcand.org.

Mandated reporters are often on the 'front lines' of identifying possible child abuse and neglect because of their established relationship with children based on their profession.

Mandated reporters are often on the 'front lines' of identifying possible child abuse and neglect because of their established relationship with children based on their profession. This is an important connection because sometimes mandated reporters are the only protection children have.

Additional child abuse and neglect-related information is also available on Prevent Child Abuse North Dakota's website or by contacting a county social service office in North Dakota.

A Recap of NDMA's 128th Annual Meeting:

Effective Physician-Patient Communication

By Katie Fitzsimmons

We are pleased to report that NDMA hosted another successful Annual Meeting. Over 55 physicians, guests, award recipients, and staff attended the 128th meeting in Bismarck at Bismarck State College's National Energy Center of Excellence. 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. Same as last year, we enrolled a condensed conference schedule which, again, worked well for all of those in attendance.

The night prior to the meeting, the NDMA PAC held a dinner at MacKenzie River Pizza, Grill, and Pub. This fun event was well attended and warmly received! Our PAC does important work to further the advocacy and networking efforts of NDMA. Thank you to all our supporters! Keep an eye out for upcoming PAC events in your area.

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, the 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 provides more updates and news from UND SMHS.

Misty Anderson, DO, serving as Speaker of the House at the 2015 House of Delegates

Dr. David O. Barbe, MD, MHA, and representative of the AMA Board of Trustees, attended the NDMA Council meeting and presented an AMA update to the House of Delegates. Dr. Barbe's presentation, "The AMA: Shaping American Health Care for Today and Tomorrow," discussed the uniting issues that concern all physicians, such as Medicare payment reform, regulatory and administrative burdens, payment and delivery system reform, scope of practice, and medical liability reform- all issues that AMA's advocacy focuses upon; the AMA's strategic plan and goals; and he honed in on the AMA/ RAND Corporation physician satisfaction survey. The

Senator Hoeven's keynote address at the annual luncheon

Dr. Deb Geier, incoming NDMA President, presenting a recognition award to Dr. Steve Strinden, outgoing president of NDMA

Award recipients from left: Dr. Bruce Hetland, Dr. Joe Adducci, and Dr. Bob Bury

2012 survey conducted field research at 30 physician organizations in six states. The two factors that stood out the most in regards to physician dissatisfaction were electronic health records and quality of care. Dr. Barbe then covered solutions in five areas that AMA is actively working on: practice transformation, physician leadership training, digital health, physician payment, and physician-organization relationships.

Dr. Barbe then expanded the message with discussion of the AMA's Accelerating Change in Medical Education Consortium. It launched in 2013 with 11 medical schools and has since expanded with another 20 schools this year, UND SMHS being one of them. You can read more about the impact of this on UND SMHS in Dean Wynne's column.

Senator John Hoeven talking with UND SMHS Dean Joshua Wynne

Dr. Lyle Thorstenson of the AMPAC Board of Directors spoke to the House of Delegates and addressed the importance of supporting advocacy on the state and federal levels. NDMA was also honored to have Terri Folk, the Regional Director of AMA in attendance, to converse with members.

Misky K. Anderson, DO, NDMA Speaker of the House, convened the House of Delegates and reviewed the presented resolutions; two were adopted with minimal adjustments and no new resolutions were introduced on the floor. The first resolution addresses standardization of prior-authorization forms and the second resolution promotes colorectal cancer screenings (also discussed in this issue). In addition to adopting two resolutions, the House of Delegates approved amendments to our by-laws to tidy up language and procedures. We included the full script on each of the resolutions and by-law actions in this issue for easy reference. You can also access them on our website. Dr. Anderson also announced the slate of officers nominated by the districts, which was accepted by the House of Delegates. The 2015 executive officers are:

From left: Senator Dick Dever, AMA Regional Director Terri Folk, and Representative Dr. George Keiser

Left-right: Heidi Nammour, NDMA Vice President and Council Chair Fadel Nammour, MD, and NDMA President Debra Geier, MD

President: Debra Geier, MD, from Jamestown, nominated by the 7th District
Vice President and Council Chair: Fadel Nammour, MD, from Fargo, nominated by the First District
Secretary-Treasurer: Misty Anderson, DO, from Valley City, nominated by the 5th District
Speaker of the House: Joshua C. Ranum, MD, from Hettinger, nominated by the 11th District
AMA Delegate: Shari L. Orser, MD, from Bismarck, nominated by the 6th District
AMA Alternate Delegate: A. Michael Booth, MD, from Bismarck, nominated by the 6th District

Congratulations to our physician leaders!

Betty VanWoert, RN, BSN, CPHRM, from the Midwest Medical Insurance Company (MMIC) presented two CME courses titled, Errors in Diagnosis:Analysis and Prevention Strategies and When Things Go Wrong: Apology and Communication. These two topics worked together beautifully. Ms. VanWoert identified approaches and tools to address diagnostic errors and she discussed the importance of open and timely communication with patients and families.

Senator John Hoeven with NDMA executive director Courtney Koebele

Besides all the learning, protocol, and procedure, there was fun to be had. The annual lunch and awards presentation, emceed by outgoing NDMA President Steve P. Strinden, MD, was fantastic. We started the lunch with a big punch: a keynote address by Senator John Hoeven. Senator Hoeven discussed the repeal of the Sustainable Growth Rate (SGR), concerns with the VA health system, the Affordable Care Act, tort reform, Independent Payment Advisory Board (IPAB) repeal, and then fielded questions from the audience. We were so fortunate to have Senator Hoeven present. His approachable and accessible manner and his depth of knowledge and understanding of the issues facing medicine today made for a most enjoyable luncheon. Thank you to Senator Hoeven and his staff for making his appearance possible- we know how busy he is and we appreciate the opportunity to have him as a guest and speaker.

After Senator Hoeven's keynote address, we honored our physicians who hit the 40-year mark in practice, including: James M. Brooke, MD, of Dickinson; Robert J. Bury, MD, of Bismarck; John C. Chatelain, MD, of Fargo; Terry Dwelle, MD, of Bismarck; Linda L. Getz-Kleiman, MD, of Fargo; Michael F. Gonzales, MD, of Glyndon; Terrence E. Grimm, MD, of Minneapolis, MN; Bruce M. Hetland, MD, of Bismarck; Anand G. Kantak, MD, of Fargo; Sunita A. Kantak, MD, of Fargo; Nathaniel L. Karlins, MD, of Fargo; Inder V. Khokha, MD, of Cavalier; Mark A. Lundeen, MD, of Fargo; Bruce A. Nelson, MD, of Fargo; Rolf R. Paulson, MD, of Grand Forks; Jeanine L. Roembach-Clark, MD, of Fargo; Casey J. Ryan, MD, of Grand Forks; Stephen A. Stromstad, MD, of Edcouch;

Duane Houdek, executive secretary of the Board of Medicine, accepts the Friend of Medicine Award on Judge Burt Riskedahl's behalf at the Annual Meeting luncheon.

Dr. Kim Krohn and Dr. Joe Adducci at the NDMA PAC dinner

Courtney Koebele with award recipient Dr. Bob Bury and Dr. Jan Bury

Leann Benson of NDMA with Dr. Ernest Godfread and Carolyn Godfread

Dr. Steve Strinden, Senator John Hoeven, and Dr. Dave Barbe

Janet K. Tillisch, MD, of Fargo; and Lawrence L. Wilder, MD, of Williston. We were thrilled Bruce Hetland, MD, and Bob Bury, MD, were present to accept their certificates.

Our Physician Community and Professional Services Award recognition was awarded to Joseph Adducci, MD. This award recognizes outstanding members of the Association who serve as role models, active in both their profession and in their community. Dr. Adducci embodies all of that and more; NDMA was honored to present this award to such a deserving, well-known, and well-respected physician and leader.

Dr. Adducci began his career in 1966. He was the first to introduce Laser procedure in North Dakota. He was also the first to introduce the Laparoscopy procedure in the state of North Dakota. For an extended duration, he was one of only six board certified OB/GYNs in the state and he served as Williston's sole OB/GYN for 35 years. In the 1970s, Dr. Adducci was instrumental in the designing and planning of the Trenton Indian Health Service Clinic along with Tony Moran, Chairperson at the time. He conducted a study of the population needs which showed that over 95 Native American children were suffering from various stages of Rickets. These findings helped push this clinic concept through and he assisted in obtaining funding for the Trenton Indian Health Service Clinic. He has provided services at that clinic throughout his career.

He was and remains active in community activities such as sponsoring softball/baseball leagues and has been an integral health care leader by serving as a member of the Mercy Hospital Board, a Williams County Health Commissioner, Chief Of Staff at Mercy Medical Center, President of State OB/GYN Society, Board Member of Blue Cross and Blue Shield, Counselor for NDMA, President of the 8th District Medical Society, and Assistant Professor for the University of North Dakota School of Medicine and Health Sciences Program. On a national level, Dr. Adducci is a Fellow of the American College of OBGYN and the American College of Surgeons; he is also a Founding Fellow of the American College of Gynecologic Laparoscopists and GYN Laser Surgery.

Dr. Adducci was presented with this honor with the thanks, admiration, and appreciation of the entire North Dakota Medical Association. NDMA was proud to recognize such a dedicated community leader and is forever humbled to have Dr. Adducci as one of our honorees.

The Honorable Burt Riskedahl was recognized with the North Dakota Medical Association's Friend of Medicine award. This 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."

Judge Riskedahl, JD, a graduate of Jamestown College (BA), University of Denver (MSW), and William Mitchell College of Law (JD), served as Judge of Burleigh County (1979-1994). In 1994, he was elected to serve as District Judge. He was re-elected to that post in 1996 and 2002; he retired from the bench in 2006. While serving as a public member of the North Dakota Board of Medicine,

Former NDMA Presidents Dr. Steve Hamar (1994-1995) and Dr. Kim Krohn (2009-2011) with NDMA executive director Courtney Koebele

Dean Wynne speaks during the breakfast at the Annual Meeting

Hoeven's keynote address at the Annual Luncheon

From left-right: Barb Groutt of Quality Health Associates of North Dakota, Tim Blasl of the North Dakota Hospital Association, and Annette Goehring of NDMA

NDMA Secretary-Treasurer (former Speaker of the House) Misty Anderson, DO, and District 5 Delegate Gigi Goven, MD

Dr. Joe Adducci, award winner, with Vivian Kockler at the PAC dinner on September 24 at MacKenzie River Pizza

Judge Riskedahl was instrumental in the passage of legislation creating the North Dakota Physicians Health Program as a separate organization dedicated to the confidential support of North Dakota's licensed physicians and physician assistants in need of substance abuse treatment and services.
For over two years, he worked methodically, laying the groundwork for the program's acceptance by the Board of Medicine and overwhelming approval by the state legislature in 2013. He studied best practices in other states and national organizations, made program site visits, and drafted legislation and the agreement between the licensing board and the new health program that allows physicians to seek help from the health program without fear of publicity or adverse licensure action. At the same time, he made sure the public was protected from those practitioners whose active disease prohibited them from practicing medicine safely.

Dr. Gaylord Kavlie, a surgeon in Bismarck, nominated Judge Riskedahl for this award because of his instrumental work with this program. In his nomination letter, Dr. Kavlie stated, "Burt saw from the beginning that creating a program where physicians felt safe would lead to treatment much earlier in the disease process. Burt championed the establishment of a program that will benefit physicians and the public in a meaningful way for years to come." NDMA was honored and proud to recognize Judge Riskedahl for all that he has done for the physicians and patients of North Dakota. Unfortunately, Judge Riskedahl was not able to accept the award in person, but there was one fortunate upside to that situation: Duane Houdek, executive secretary of the Board of Medicine, was able to accept the award on his behalf. In doing so, Duane was able to illustrate Burt's character, integrity, and true compassion.

To close the luncheon program, Dr. Debra Geier, the new NDMA President, presented a plaque to Dr. Steven Strinden, NDMA's outgoing president, to recognize his dedication to NDMA not only during his presidential tenure, but throughout these last eight years of service as an executive board member, and for the years prior of active participation as a physician leader. Dr. Geier read a resolution to recognize the good works and dedication of Dr. Strinden:

The NDMA annual luncheon

A Resolution Recognizing North Dakota Medical Association President STEVEN P. STRINDEN, MD

WHEREAS, Steven P. Strinden, MD, has dedicated his professional life to the practice of medicine and to the health of the public, specializing in urology and urological surgery in North Dakota; and

WHEREAS, Dr. Strinden has demonstrated unending devotion and commitment to his community, profession, and patients; and

WHEREAS, Dr. Strinden served earnestly and effectively as President of the North Dakota Medical Association from October of 2013 to September of 2015; and

WHEREAS; prior to his service as NDMA President, Dr. Strinden served NDMA as Chairman of the NDMA Council from 2011 to 2013, as Secretary-Treasurer from 2009 to 2011; as Speaker of the House from 2007 to 2009; as Councillor for First District from 2004-2007; and

WHEREAS, as President, Dr. Strinden stressed the importance of support for NDMA members through the massive changes occurring in medicine, and his theme of "'The Golden Years of Medicine Are Ahead of Us" reflected the importance of physician leadership and the imperative that physicians lead the changes occurring in healthcare; and

WHEREAS, Dr. Strinden served during a time of unprecedented national public debate about health system reform and reform to the Medicare payment system, including repeal of the Sustainable Growth Rate (SGR) as well as state debate about important issues regarding the patient-physician relationship; and

WHEREAS, Dr. Strinden ensured that NDMA maintained a high profile in both the Congress and the 2015 North Dakota Legislative Assembly, before state agencies and other organizations, and fulfilled its responsibility as advocate for the best interests of our patients; now

THEREFORE, BE IT RESOLVED, that the House of Delegates of the North Dakota Medical Association enthusiastically expresses its gratitude and appreciation to President Steven Strinden.

Thank you, Dr. Strinden, for always being a champion of medicine, an active leader, an outstanding physician, and most importantly, a true friend to NDMA.

Following the luncheon, the House of Delegates reconvened for the final passage of the resolutions and for Dr. Debra Geier's inaugural address. We are honored to have Dr. Geier at the helm of this ship. Please take a moment to read her first Physician Advocate column at the beginning of this issue of *ND Physician*. As you can see, NDMA continues to be in good hands.

With many complicated issues lacing the practice of medicine, talking with others in the field and gaining greater perspective from outside entities proves fruitful for all physicians. The NDMA Annual Meeting continues to be a source of education, fellowship, and networking, and we hope you join us at our next gathering. We are working on 2016's Fargo Meeting which is set for October 6, 2016. Mark your calendars now and stay tuned for updates and information!

STANDARD PRIOR-AUTHORIZATION FORM

Introduced By: NDMA Council
Subject: Standardized Prior-Authorization Form

1) **WHEREAS**, data shows that, on average, physicians reported spending three hours weekly interacting
2) with plans; nursing and clerical staff spent much larger amounts of time. When time is converted to
3) dollars, nationally, physician practices spend at least $23 to $31 billion each year interacting with plans;
4) and
5) **WHEREAS**, depending on the patient and the insurer's authorization requirements for that patient, this
6) can require a different form or forms for every patient seen in the office on any given day; and
7) **WHEREAS**, unreimbursed administrative tasks increasingly burden physician practices, including
8) obtaining prior authorization, working with multiple formularies, editing of claims, reviewing accuracy of
9) quality data, maintaining EHRs or registries, and coordinating care; and
10) **WHEREAS**, a single transparent set of payment rules for multiple payers, a single claim form, a standard
11) set of rules for claim submission and editing would reduce unfunded mandates for physician practices;
12) **THEREFORE, BE IT RESOLVED** By the 2015 House of Delegates of the North Dakota Medical
13) Association that NDMA work with payors, health systems, and other stakeholders to develop a
14) standardized prior authorization form and seek legislation; and be it
15) **FURTHER RESOLVED**, that NDMA will work to develop a standardized process for the submission,
16) review, approval/denial and appeal of prior authorization requests.

PROMOTING COLORECTAL CANCER SCREENING

Introduced By: NDMA Council
Subject: Promoting Colorectal Cancer Screening

1) **WHEREAS**, Colon cancer is the third most frequently diagnosed cancer and second most
2) common cause of cancer death for both men and women; and
3) **WHEREAS**, the National Colorectal Cancer Roundtable (NCCRT), a national coalition of
4) private, public, and voluntary organizations, vowed to achieve 80% of adults beginning at the
5) age of 50 to be screened by 2018; and
6) **WHEREAS**, it is estimated that by increasing screening rates to 80% by 2018, new colon cancer
7) cases would be reduced by 17% and death rates by 19% by the end of 2020; and
8) **WHEREAS**, 1 in 3 adults between the ages of 50 and 75 are not up-to-date with recommended
9) colorectal cancer screening, nearly 132,700 individuals will be diagnosed in the United States,
10) 49,700 individuals will die from the disease; and
11) **WHEREAS**, if a diagnosis happens during the localized stage, the 5 year survival rate is 90%.
12) Currently, 39% of cases are diagnosed at this localized stage. If not detected until late stage, 5
13) year survival rates drops to less than 12%; and
14) **WHEREAS**, each year approximately 400 North Dakota Men and Women will be diagnosed
15) with colorectal cancer and 140 North Dakotans will die from the disease; and
16) **WHEREAS**, 43% of North Dakotans diagnosed with colorectal cancer are diagnosed after the
17) cancer has begun to spread outside the colon. Yet, 42% of age-eligible North Dakotans have
18) never been screened for colorectal cancer or are past due for screening; and
19) **WHEREAS**, North Dakota ranks 42nd in the nation for rates of colorectal cancer screening,
20) placing the state in the lowest quartile nationally; and
21) **WHEREAS**, Colorectal cancer treatment costs the U.S. $8.4 billion per year; and

1) **WHEREAS**, existing medical technology can detect signs of this cancer long before it becomes
2) deadly with one of several effective screening methods for average-risk individuals age 50 and
3) over and screening methods of the highest sensitivity (colonoscopy) for those at increased risk;
4) and
5) **WHEREAS**, if the health care community is able to support the NCCRT's goal of increasing
6) colon cancer screening to 80% by 2018 in the United States, 280,000 new cancer cases and
7) 200,000 cancer deaths could be averted within 20 years.
8) **THEREFORE, BE IT RESOLVED**, that NDMA in collaboration with other public and private
9) organizations/agencies serving the aging population and those with cancer; 1) urge insurers and
10) employers to remove barriers to colorectal screening (and related diagnostic work-up) by
11) providing full coverage without co pays or deductibles for all of the updated screening options
12) including FIT/FOBT tests, which can be performed annually for individuals of average risk; 2)
13) urge state and local health departments to include colorectal cancer in all cancer screening
14) programs and to promote screening to their client populations, and 3) support improved primary
15) care and continued education of public health professionals.

PROPOSED AMENDMENTS TO NDMA BYLAWS

Recommendation by the Council to the House of Delegates

Section 5 of Chapter IV of the Bylaws of the North Dakota Medical Association is amended as follows:

SECTION 5. The House of Delegates shall elect the Delegates(s) and the alternate Delegate(s) to the American Medical Association. The term of this office shall be two years beginning January 1 after the election. An active member so election may serve three consecutive two-year terms as an alternate delegate and three consecutive two-year terms as a delegate. An Active member who serves three consecutive two-year terms as alternate delegate or delegate may not be reelected to that office unless the office is held by another Active members for at least one term immediately preceding the reelection. If before the expiration of the term for which elected an AMA Delegate is unable or unwilling to complete his or her term, the AMA Alternate Delegate shall succeed to the office of AMA Delegate. Vacancies in the office of AMA Alternate Delegate shall be filled by appointment by the Council for the unexpired portion of the term, or until the next Annual Meeting.

Chapter V of the Bylaws of the North Dakota Medical Association is amended as follows:

CHAPTER V
DUTIES OF OFFICERS

SECTION 1. The duties of the President shall be: to preside at all general meetings of the Association; to appoint the members of all commissions, task forces, and committees; to deliver an annual address at such time as may be arranged; to be the spokesperson for the profession during the term of office and attend meetings of the District Medical Societies; to visit the members to become familiar with local issues affecting the practice of medicine; to be an ex-officio member of all commissions; to designate the areas of responsibility for the Vice-President; and to perform such other duties as necessary. The President may receive financial remuneration as determined by the Council.

SECTION 2. The Vice-President shall serve as the chairman of the Council. The Vice-President shall assist the President in the performance of the President's duties. During the President's absence, or at the request of the President, the Vice-President shall assume the duties of the President. ~~In case of death, resignation or removal of the President, the Vice-President shall assume the duties of the President. The Council shall elect a Chairman of the Council to serve the remaining unexpired term.~~

SECTION 3. The Secretary-Treasurer shall attend the meetings of the Association, the House of Delegates, and the Council, and keep records of their respective proceedings. The Secretary-Treasurer shall report on the financial status of the Association at each meeting of the Council, and shall submit an annual fiscal year report. The Secretary-Treasurer shall provide for the registration of the members and delegates at the Annual Meetings. The Secretary-Treasurer shall provide for an external audit of the financial records of the Association not less than once every three years.

SECTION 4. The Speaker of the House of Delegates shall preside at the meetings of the House of Delegates. The Speaker shall have the right to vote only when necessary to break a tie. ~~In case of the Speaker's death, resignation or removal, the Council shall appoint a Speaker for the remainder of the term, and the resulting vacancy shall be filled at the time of the next regular election.~~

SECTION 5. Vacancies created by the death, resignation, or removal of officers shall be filled by appointment by the Council for the unexpired portion of the term. The period of service by an appointee under this section to an unexpired term will not disqualify that person from serving a subsequent full term in the office to which appointment was made.

SECTION ~~5~~ 6. Executive Director. The Council shall employ, and determine the compensation of an Executive Director. The Executive Director shall provide, at the Association's expense, a bond in an amount determined by the Council. The Council shall approve a job description for the Executive Director. The Executive Director shall give a report of the staff activities at the Annual Meeting of the Association, or as requested by the President or the chairman of the Council.

SECTION ~~6~~ 7. The officers are ex-officio members of all commissions, task forces, and committees.

Chapter VII of the Bylaws of the North Dakota Medical Association is amended as follows:

SECTION 1. The standing commissions of the North Dakota Medical Association shall be a:

Commission on Medical Services and Public Relations to address the health and well-being of the citizens of North Dakota, public relations of the Association, and to be a liaison with other organizations of mutual interests;

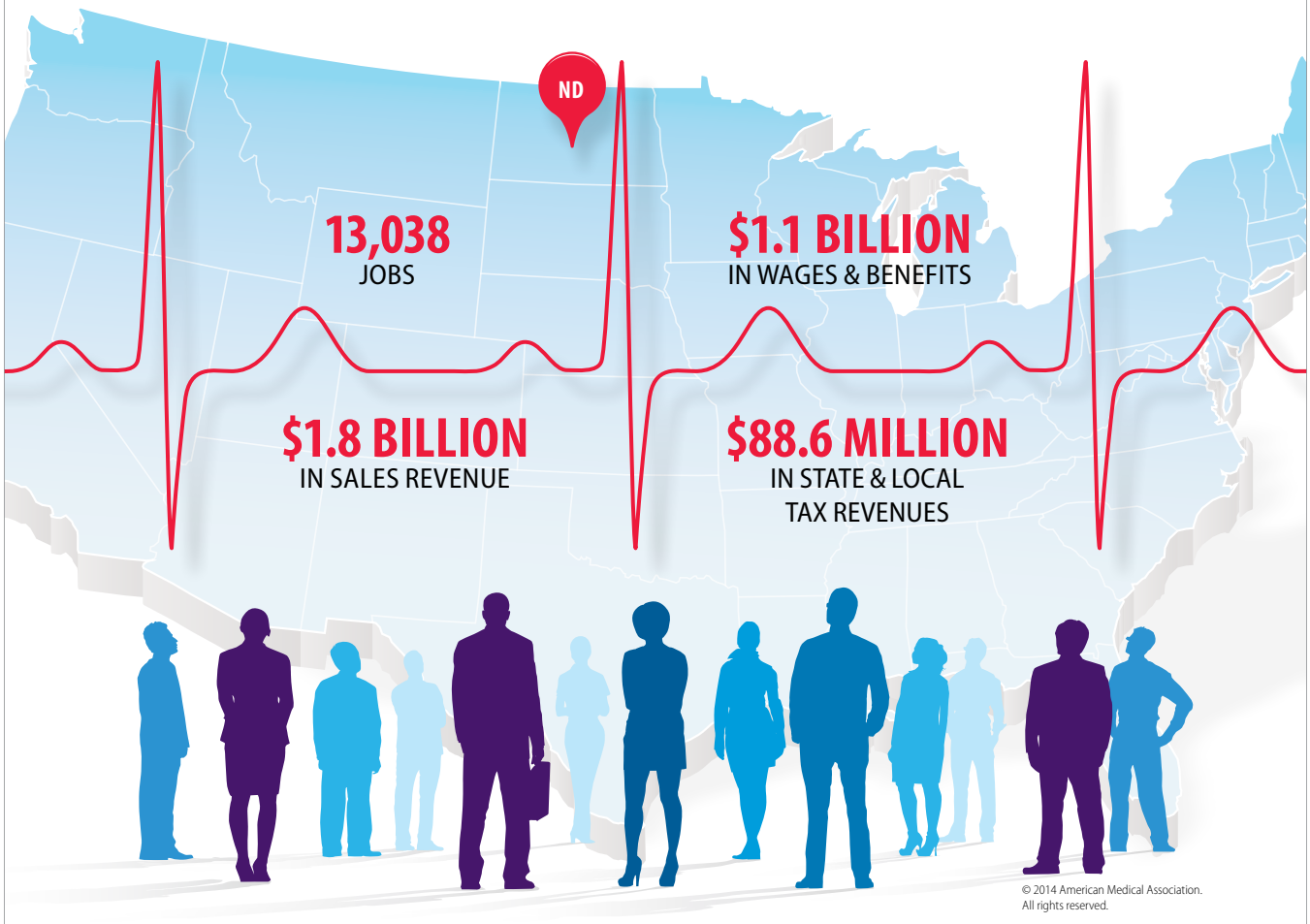
Commission on Medical Education to be an advocate for all levels of medical education, to be a liaison between the Medical School and the Association, to be a liaison between the American Medical Association Medical Student Section and University of North Dakota School of Medicine and Health Sciences, and to support the continuing medical education activities of the Association, ~~and to oversee the Association's continuing medical education accreditation program;~~

Commission on Legislation and Governmental Relations to address all appropriate legislation and actions of governmental agencies;

Commission on Socio-Economics to address medical economics;

Commission on Ethics to be a liaison with the North Dakota State Board of Medical Examiners and to provide guidance to members concerning ethical issues.

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.

PHYSICIANS BOOST THE ECONOMY.

See the effect in North Dakota

North Dakota's physicians are trusted leaders who have a positive and lasting impact on the health of their patients and the health of their community as a whole. Physicians also critically support the health of their local and state economies through the creation of jobs with their related wages & benefits, the purchase of goods and services and large-scale support of state and local tax revenues.

Results from a recent economic impact study conducted by IMS Health, on behalf of the AMA, demonstrate the significant level of support that physicians generate for North Dakota's economy. The study results also clearly indicate that creating an environment which would attract new and retain existing physicians to meet expanding healthcare demands will also have the added benefit of increasing the number of good jobs in North Dakota and improving the health of the local economy.

Key economic benefits provided by physicians both nationally and in North Dakota in 2012 include:

	North Dakota	National
TOTAL PATIENT CARE PHYSICIANS	**1,560**	**720,421**
JOBS		
Total Direct Jobs Supported by Physician Industry [1]	7,235	3,336,077
Total Indirect Jobs Supported by Physician Industry [1]	5,803	6,632,265
Total Jobs Supported by Physician Industry [1]	13,038	9,968,342
Average Jobs Supported by Each Physician Including His/Her Own [1]	8.4	13.8
SALES REVENUE		
Total Sales Revenue Generated by Physician Industry [1]	$ 1.8 Billion	$ 1.6 Trillion
% of Total GSP/GDP [2]	4.0%	10.2%
WAGES & BENEFITS		
Total Wages & Benefits Supported by Physician Industry [1]	$ 1.1 Billion	$ 775.5 Billion
LOCAL & STATE TAX REVENUE		
Total Local & State Tax Revenue Generated by Physicians [1]	$ 88.6 Million	$ 65.2 Billion

NDMA NORTH DAKOTA MEDICAL ASSOCIATION

AMA AMERICAN MEDICAL ASSOCIATION

1. *The State Level Economic Impact of Physicians Report (IMS Health, March 2014)*
2. *US Bureau of Economic Analysis: Current-Dollar GDP by State, 2012*

8 Reasons Patients Don't Take Their Medications

From the American Medical Association

Medication nonadherence—when a patient doesn't take their medication as prescribed—is unfortunately fairly common, especially among patients with chronic disease. Learn eight reasons why patients don't take their medications and ways your team can help identify and improve patients' adherence to their medications.

Patients can be reluctant to tell you that they don't take their medicines. If you don't have a true picture of a patient's medication-taking behavior, you may needlessly escalate his or her treatment, resulting in potential harm to the patient, unnecessary work for the practice, and increased costs overall.

Data show about one-quarter of new prescriptions are never filled and patients do not take their medications about 50 percent of the time. Most nonadherence is intentional—patients make a rational decision not to take their medicine based on their knowledge, experience, and beliefs. The top eight reasons for intentional nonadherence are:

- **Fear**
  Patients may be frightened of potential side effects. They may have witnessed side effects experienced by someone else who was taking the same or a similar medication and believe the medication caused the problems

- **Cost**
  Patients may not fill medications in the first place or ration what they do fill to extend their supply

- **Misunderstanding**
  Patients may not understand the need for the medicine, the nature of the side effects, or the time it will take to see results. This is particularly true for patients with chronic illness, because taking a medication every day to reduce the risk of something bad happening can be confusing. Failure to see immediate improvement may lead to premature discontinuation

Data show about one-quarter of new prescriptions are never filled and patients do not take their medications about 50 percent of the time.

- **Too many medications**
  The greater the number of different medicines prescribed and the higher the dosing frequency, the more likely a patient is to be nonadherent

- **Lack of symptoms**
  Patients who don't feel any differently when they start or stop their medicine might see no reason to take it

- **Worry**
  Concerns about becoming dependent on a medicine also lead to nonadherence

- **Depression**
  Patients who are depressed are less likely to take their medications as prescribed

- **Mistrust**
  Patients may be suspicious of their doctor's motives for prescribing certain medications because of recent news coverage of marketing efforts by pharmaceutical companies influencing physician prescribing patterns

Fortunately, a free online module can help you address these reasons and improve medication adherence in your practice. The module, part of the AMA's STEPS Forward collection, includes practical strategies and tools that you can immediately implement with your practice team.

The module also includes information about how to get support for intervention implementation, and it offers continuing medical education credit. More than 25 modules are expected to be available in the AMA's STEPS Forward collection by the end of the year.

5 Barriers to Hypertension Control: What They are and How to Address Them

From the American Medical Association

Given that one in three US adults has hypertension, nearly all physicians face the challenge of helping their patients control their blood pressure. But addressing hypertension effectively in practice can be difficult. Learn the barriers to hypertension control and what you can do to address them in your practice.

Five common barriers to hypertension control are:

1. Poor or inconsistent blood pressure measurement techniques
2. "White coat effect," which causes a temporary elevation in a patient's blood pressure during an office visit in a person with normal blood pressure outside of the office
3. Clinical inertia, which occurs when the care team does not initiate or intensify treatment during an office visit if the patient's blood pressure isn't at a goal level, or failure to schedule frequent follow ups when indicated
4. Lack of use of evidence-based treatment protocols by the care team
5. Poor patient participation in self-management behaviors

Fortunately, physicians can use a free online module to address all six barriers and get their patients' blood pressure under control. The module, part of the AMA's STEPS Forward website, includes practical strategies and tools that you can immediately implement.

The module is built off of a checklist called the "M.A.P. for achieving optimal blood pressure control," developed by the AMA, Johns Hopkins Medicine, and physicians in pilot sites across the country to improve outcomes around hypertension. The pilot practice sites also tested and helped evolve the tools. The M.A.P. calls for physicians and care teams to Measure blood pressure accurately, Act rapidly to reduce clinical inertia, and Partner with patients, families and communities to promote patient self-management.

The M.A.P. framework includes a number of resources, which are products of the AMA's Improving Health Outcomes initiative. Under this initiative, the AMA and participating physicians and care teams are working with researchers at the Johns Hopkins Armstrong Institute for Patient Safety and Quality and the Johns Hopkins Center to Eliminate Cardiovascular Health Disparities to develop, test, and spread an evidence-based program to improve blood pressure control nationally.

The following resources also provide simple practical tips you can use to help your patients get their hypertension under control:

- **Get the one graphic you need for accurate blood pressure readings**
- **Read how a physician used the M.A.P. to help a patient change his life**
- **Learn the three questions you should ask patients when measuring their blood pressure**
- **Hear what other physicians are doing to control hypertension in their practices**
- **See how you can help patients manage blood pressure outside of office visits**

Breast Density and the Physician's Role

Barbara Steiner
Women's Way Clinical Coordinator
Nurse Consultant

During the month of October, a series of articles covering dense breast notification were sent out as part of the North Dakota Medical Association's weekly *e-Checkup*. This article contains a summary of the information plus some additional things to consider.

North Dakota is one of 24 states with a dense breast notification law. The North Dakota State Legislature passed HB 1370 that requires a facility that performs mammography examinations to provide written patient notification in the event that a patient is categorized as having heterogeneously dense breasts or extremely dense breasts. The report/letter sent to the patient must include the following:

- The patient has dense breast tissue
- Dense breast tissue may make it more difficult to detect cancer on a mammogram
- Dense breast tissue may increase the patient's risk of breast cancer

The American College of Radiology categorizes breast density into four levels:

- Almost entirely fatty – breasts are almost entirely composed of fat (10% of women)
- Scattered areas of fibroglandular density – there are some scattered areas of density, but the majority of breast tissue is not dense (40% of women)
- Heterogeneously dense – there are some areas of non-dense tissue, but the majority of the breast tissue is dense (40% of women)
- Extremely dense – nearly all the breast tissue is dense (10% of women)

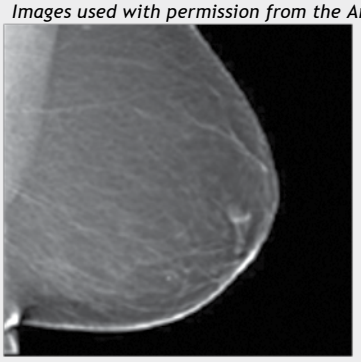
Mammography patients receive a letter advising them of the results of their mammogram (positive or negative), but now those patients that have been categorized as having 'heterogeneously' or 'extremely dense' breasts will also receive additional notification that they have dense breast tissue.

A letter sent to a woman may say:

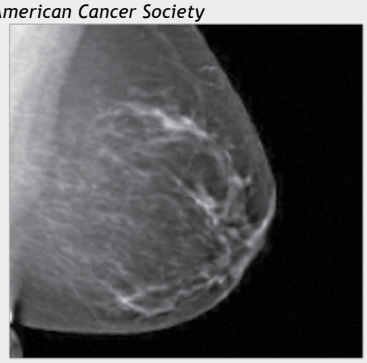
Your recent mammogram shows that your breast tissue is dense. Dense breast tissue is very common and is not abnormal. Dense breast tissue can make it harder to detect cancer on a mammogram. Also, dense breast tissue may increase your breast cancer risk. This information about the result of your mammogram report is given to you to raise your awareness. Use this report when you talk to your doctor about your own risks for breast cancer, which includes your family history. At that time, ask your doctor if more screening tests might be useful, based on your individual circumstances.

Physicians will need to help patients, who receive this information about breast density, understand breast density and explore the need for additional imaging based on her personal medical history and breast cancer risk.

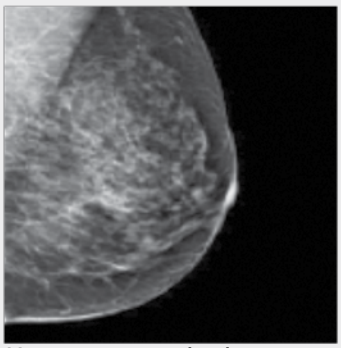
Images used with permission from the American Cancer Society



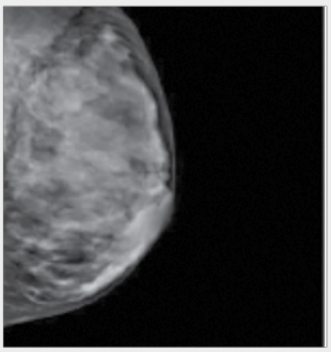
Almost entirely fatty



Scattered areas of Fibroglandular density



Heterogeneously dense



Extremely dense

Health care facilities may have completed guidelines for physicians to use to aid in the decision making process for additional imaging. If this process is not in place, tools such as the National Cancer Institute's breast cancer risk calculator (does not include breast density in calculation) or the Breast Cancer Surveillance Consortium's breast cancer risk calculator (breast density included in calculation), may be helpful to assess a patient's level of risk for breast cancer and the need for additional imaging. Types of additional imaging that might be discussed with patients include 3D mammography (tomosynthesis), breast ultrasound, breast MRI, and/or breast specific gamma imaging (BSGI), depending on your location and the resources available to you in your practice. Currently there is no formal recommendation from the American College of Radiology regarding additional screening beyond mammography based solely on breast density. Insights regarding breast density and the need for additional imaging were provided in the January 2014 Radiology Today Interview with Carol H. Lee, MD, FACR.

The potential costs of any additional testing is another point of consideration. Women should be informed that not all insurance plans cover the cost of additional imaging and to check with their plan regarding the coverage for these procedures.
Overall, the aim of all supporting organizations and healthcare providers is to present readily available information to patients in order for each of them to make an informed decision about this important health topic.

Physicians will need to help patients, who receive this information about breast density, understand breast density and explore the need for additional imaging based on her personal medical history and breast cancer risk.

NORTH DAKOTA DEPARTMENT of HEALTH

RESOURCES

For providers:
Breast Density Handout for Providers

For patients:
American College of Radiology
American Cancer Society
North Dakota Cancer Coalition

Breaking Down Silos

Erin Hill-Oban, executive director of Tobacco Free North Dakota

One thing I have learned during my relatively short time in policy work, whether in my advocacy and education work with non-profits or now through government efforts as a legislator, is that too often, we work in silos. Naturally, and sometimes understandably, we get caught up in our individual day-to-day responsibilities at the expense of the bigger, broader picture and long-term missions that bind us. At Tobacco Free North Dakota (TFND), we are appreciative of the working relationship that continues to be strengthened and the vision we definitely share with the NDMA and its members: to improve and protect the health of all those we serve.

A patient who quits cold turkey and with no support can expect only a 3% success rate. Upon receiving just your suggestion to quit, that rate goes up to 8-12%.

In partnership with both BreatheND and the North Dakota Department of Health, TFND contacted any and all of our state's medical professionals across all disciplines, regardless of whether that care is delivered within a large healthcare system or an independent practice, to promote a simple yet impactful goal: the implementation of addressing tobacco use as a vital sign at every visit just as you do, say, blood pressure, pulse, and weight.

The good news is that many of you, especially with the assistance and expansion of electronic health records, are potentially, and at least partially, already doing this. However, there likely remains room for improvement, and that improvement can be made by implementing the 5 A's or AAR (depending on your clinical setting).

The 5 A's
Ask about tobacco use
Advise tobacco users to quit
Assess readiness to quit
Assist with a quit plan
Arrange follow up visits

This is best implemented during in-patient services or when a provider will directly facilitate a patient's quit plan from beginning to end.

AAR
Ask about tobacco use
Advise tobacco users to quit
Refer patients to counseling and cessation services.

This method is best implemented in settings where a patient will receive either in-house counseling/cessation assistance, if available, or will simply be referred to an outside service like NDQuits.

Either way, following these public health service guidelines is efficient (maybe a 90-second process), can be delivered by nurses or other support within your office, and most importantly, are incredibly effective. We have oodles (obviously a technical term) of documentation demonstrating that you are absolutely the best "quit" messenger and referral source, better than mass media, advertising, family, friends, or employers.

Additionally, tobacco quit rates are markedly more successful when you advise a patient to quit. A patient who quits cold turkey and with no support can expect only a 3% success rate. Upon receiving just your suggestion to quit, that rate goes up to 8-12%. Couple that with the use of programs like NDQuits, which combines both counseling and the use of nicotine replacement therapies, and success rates rise to 30%!

As you know, getting patients off tobacco has a significant impact on almost all other health outcomes, including, but not necessarily limited to, why they have come to see you. We have come a long way, thanks in huge part to our providers, in making system changes that improve patient care and treat the whole self. At TFND, we deeply admire and respect the care North Dakotans receive from our state's healthcare providers and are here to provide technical or other assistance to support your implementation of or improvements to the use of the 5 A's or AAR in your practice.

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.

2016 Events Calendar

January 7-9, 2016

AMA State Legislative Strategy Conference
Loews Ventana Canyon Resort,
Tucson, AZ

January 15, 2016

North Dakota Society of Eye Physicians and Surgeons Meeting and UND Hockey Game Social
Grand Forks, ND

January 18-22, 2016

NDAFP Big Sky Conference
Big Sky, MT

Contact NDAFP for information

February 22-24, 2016

AMA National Advocacy Conference
Washington, D.C.

March 3, 2016

Senior Healthcare Professional Summit
Bismarck, ND

Contact CHI St. Alexius for information

April 21-23

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

Contact the ND Chapter office at 701-223-9475 for information

April 30, 2016

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

Contact the NDOS office at 701-223-9475 for information

May 14-18, 2016

American Psychiatric Association Annual Meeting
Atlanta, GA

June 11-15, 2016

AMA Annual Meeting
Hyatt Regency Hotel
Chicago, IL

September 9, 2016

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

October 6, 2016

NDMA Annual Meeting
Hilton Garden Inn
Fargo, ND

October 14, 2016

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