ND Physician

December 2016

NDMA
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DISCOVER. *INSPIRE.* **GROW.**

Edith Sanford Breast Center Symposium

Friday, March 3, 2017

SAVE THE DATE: Friday, March 3, 2017
Courtyard by Marriott Fargo-Moorhead,
1080 28th Avenue South, Moorhead, MN

Please join us to learn from local and national breast cancer experts.

Physicians, nurses, research scientists, advanced practice providers, genetic counselors, residents and students are invited.

For more information, email Jessica Aguilar at jessica.aguilar@sanfordhealth.org.

SANFORD
Edith Sanford
BREAST CENTER

ND Physician

In this Issue

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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ND Physician is published by the
North Dakota Medical Association,
1622 East Interstate Avenue, Bismarck, ND 58503
Phone: 701-223-9475 Fax: 701-223-9476
E-mail: staff@ndmed.com

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Clarification:
The Altru Health System article on page 20 of the August issue of the ND Physician magazine entitled: "Mohs Surgery: The Skin Cancer Treatment With the Highest Cure Rate" the first sentence should have stated: *Truyu Aesthetic Center, a part of Altru Health System, is happy to introduce Bishr Al Dabagh, MD, FAAD; Dr. Bishr Al Dabagh is the only fellowship trained Mohs surgeon in Grand Forks.*

Physician Advocate

Participate in the Advocacy that Shapes our Healthcare Policy

"I have always strenuously supported the right of every person to their own opinion, however different that opinion might be to mine."

— Thomas Paine

Debra Geier, MD, NDMA President

I take pen to paper, or in this day and age – fingers to keyboard, this November 9, 2016 – the day after our general election. My 4th grader is taking a social studies test today that focuses on our United States government. What a wonderful thing to once again study the origins and evolution of our democracy...and with a 4th grader! Our government's history is amazing, but no more amazing than the present day. Both locally and nationally, we are truly living in changing and historic times.

North Dakotans are accustomed to change. I suspect it has to do with the relentless passing of the seasons. On these glorious 70 degree November days, we are not easily deceived. North Dakotans know what lies ahead – namely the cold, dark days of winter. We also have come to appreciate the beauty within, such as how the cold feels clean and fresh, the sparkling wonder of snow and ice, and the cozy feel of hibernating in a warm and safe haven. North Dakotans will persevere. Let 'Ol Man Winter come! On the other side will be spring, and the sun will shine bright once again.

There is a high level of uncertainty on this post-election day. Nationally, the President Elect and Republican Congress are having preliminary discussions about reforming the reform, also known as making changes to or repeal of the Affordable Care Act. On a state level, the inauguration of a new governor is on the horizon. With continued budget constraints, a new governor and several fresh faces in the upcoming 65th ND Legislative Assembly, the positions on key issues related to healthcare have yet to be defined. Your NDMA continues to be poised to represent you as physicians as these issues take shape.

As this election cycle has clearly illustrated, the key to a successful democratic process is citizen participation. With the ND legislative assembly quickly approaching, efforts in our state are only just beginning. Please take a few moments to consider how you can be involved. There are a host of options including maintaining or initiating contact with a district legislator, being present at Physician Day at the Capitol, helping educate colleagues as issues move forward, or being willing to testify at legislative committee hearings. This is but a small sampling of the possibilities. If you have interest in a particular issue, contact the NDMA office. Courtney Koebele, NDMA executive director, is eager to offer guidance and partner with you for meaningful advocacy. Legislators need to know how policy may affect both physicians and patients in their communities. Physicians serve as a broad source of information for legislators on healthcare topics.

In this changing landscape, I have no doubt that the physicians of North Dakota will continue to make every effort, and take every precaution, to maintain the safety and health of their patients.

In this changing landscape, I have no doubt that the physicians of North Dakota will continue to make every effort, and take every precaution, to maintain the safety and health of their patients. We have our work cut out for us for certain. Thank you for your dedication to your profession and for your participation in the advocacy that shapes our healthcare policy.

North Dakota 2017 Legislative Session Preview

Courtney M. Koebele, JD
NDMA Executive Director

The 2016 election campaign is over; the 2017 ND Legislative Assembly and 115th Congress are poised to begin. The 2017 North Dakota Legislature will have 26 new House members and 10 new Senators, for a total of 36 new legislators, or 25% of the full legislative assembly. This is an extraordinarily high number of legislators who are new to the legislative process and don't know the background of many legislative issues.

Therefore, it is more important than ever that physicians take the opportunity between now and the January 3rd start of the session to try to meet these new legislators and give them some background of the issues facing the state.

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The 2017 Legislature selected its committees during its Organizational Session December 5-7, 2016. The Republicans have an 81-13 majority in the House and a 38-9 majority in the Senate.

The Republicans elected their leadership in November. Both Dickinson Senator Rich Wardner and Fargo Representative Al Carlson were re-elected as majority leaders without opposition. Senator Jerry Klein and Representative Don Vigesaa were re-elected as assistant Republican majority leaders. Minot Representative Larry Bellew was elected as the Speaker of the House and Dickinson Representative Mike Lefor as house caucus chairman.

Democrats elected Senator Joan Heckaman of New Rockford and Representative Corey Mock of Grand Forks as minority leaders. Senator John Grabinger of Jamestown and Fargo Representative Kathy Hogan were elected assistant minority leaders. Minority caucus leaders elected were Fargo Representative Joshua Boschee, and Fargo Senator Carolyn Nelson.

The 2017 ND Legislative Assembly convenes January 3. The executive budget, which will impact physicians through Medicaid, the UND School of Medicine & Health Sciences, and other ways, was unveiled during the organizational session in early December. Unfortunately, the budget provides that Medicaid reimbursement is at Medicare levels and Medicaid expansion will be lowered to Medicare level on July 1, 2017. This is the outgoing governor Jack Dalrymple's budget, and we will have to see if incoming Governor Burgum makes any changes. As in every session, NDMA will work to improve and protect the physician practice environment, the patient-physician relationship, and support initiatives to improve the health of the public.

The number of bills affecting health care will be increasing throughout the next several weeks, until the deadline for final bill submittal in January 2017. However, several bills, developed by the interim committees, have been adopted by Legislative Management and will go forward in the 2017 Legislative Session in the follow areas:

Medicaid Expansion: Medicaid Expansion, approved by the Legislature in 2013, covers individuals under the age of 65 (including "childless adults") with incomes below 138 percent of the federal poverty level. It provides coverage for those who make too much to qualify for traditional Medicaid but not enough to qualify for health insurance subsidies. This is a population that was never covered before under traditional Medicaid and is set to sunset July 31, 2017.

The Health Care Reform Committee, chaired by Representative George Keiser, recommended three bills regarding of Medicaid Expansion. All three bills remove the sunset provision, but the bills vary as to details. One bill sets provider reimbursement rates the same as the provider reimbursement rates set for traditional Medicaid and removes the requirement Medicaid Expansion be provided through a private carrier or by utilizing the health insurance exchange. The second bill directs the Department of Human Services (DHS) to pursue a federal Medicaid waiver to allow the department to implement premium cost-sharing for individuals enrolled in Medicaid Expansion if the cost-sharing program does not have a negative fiscal effect for the state and further directs the department to pursue care coordination agreements to increase federal reimbursement for Medicaid-eligible American Indians. The final bill provides that if the DHS contracts with a private carrier, the contract must provide the department with full access to provider reimbursement rates and the department is directed to consider these rates in selecting a private carrier; and to direct the department to report to the Legislative Management regarding provider reimbursement rates under the Medicaid Expansion program.

Medicaid expansion provides coverage to 20,000 ND citizens and the 2015–2017 North Dakota economic impact is $542 million with a federal match of 90%.

Telemedicine: The Employee Benefits Committee recommended that the PERS Proposal adopted in 2015 be applied to all payors. The bill would require the medical benefits coverage of services provided by a health care provider by means of telehealth to be the same as medical benefits coverage for the same services provided by a health care provider in-person.

- The bill mandates the medical benefits coverage for telehealth services be expanded to all medical insurance plans in North Dakota.
- The bill does not cover telehealth services that are not medically necessary or if the policy would not provide coverage if the health services or expenses for health services were provided by in-person means.
- Actuarial analysis: The consulting actuary reported PERS covers health services that are delivered by telehealth in the same manner as health services provided in-person. Female infertility, behavioral health, and sleep apnea were the top three diagnoses for the first year of this program, with 431 claims totaling $94,627.
- Telehealth has enabled patients in the rural and outlying areas of the state to continue to see their specialist residing in one of the state's four major cities without having to travel hundreds of miles.

Human Services Committee, chaired by Representative Kathy Hogan, recommended several bills to move forward to the 2017 legislative session.

Family Caregiver Supports and Services: The bill provides appropriations, including one-time funding of $197,580 from the general fund to the NDSU Extension Service for establishing a pilot project to expand local training programs to include family caregiver training, $200,000 of federal funds to DHS to administer the Lifespan Respite Care Program, and $1,535,000 from the general fund to DHS to provide an inflationary adjustment to the service payments for elderly and disabled sliding fee schedule. The bill also directs DHS to establish and promote a caregiver resource center website, to review long-term care services, and to provide recommendations to Legislative Management of options to increase the number and level of services and funding provided for home- and community based services.

Caregiver Act: The committee recommended a bill to require hospitals to establish and maintain written discharge policies. This is a shorter version of a caregiver bill that was defeated in 2015, mainly because hospitals opposed the unfunded mandates for discharge protocols that were already in place.

Policy Changes Not Requiring Additional Funding:

- Extend the holding period from 24 hours to 72 hours for emergency involuntary commitments for individuals with a serious physical condition or illness;
- Change youth mental health training requirements to require each school district to provide a minimum of 8 hours of professional development on youth mental health each biennium for teachers, paraprofessionals, administrators, and encourage ancillary and support staff to participate; to require at least 2 of the 8 hours to be used to address a school district's needs assessment results, which may include social and emotional learning; and to require each school district to report professional development hours to the Department of Public Instruction;

- Require behavioral health training for early childhood service providers; and
- Create a children's behavioral health task force.

Program Expansion with Additional Funding Requirements:

- Appropriate one-time funding of $10,000 from the general fund and require DHS to adopt rules for an evidence-based alcohol and drug education program for individuals under 21 years old in violation of NDCC Section 5-01-08;
- Appropriate $1,956,000 from the general fund to DHS for children's prevention and early intervention behavioral health services;
- Appropriate $70,000 from the general fund to DHS for a behavioral health database;
- Appropriate $1,920,000 from the general fund to DHS for peer-to-peer and family-to-family support services;
- Appropriate $24,393,668, of which $12,196,834 is from the general fund, and authorize 1 full-time equivalent position for DHS for targeted case management services for individuals with severe mental illness and severe emotional disturbance.

A Bill That Affects the Role and Function of DHS:

- Change behavioral health definitions;
- Change administration of behavioral health programs to define the roles for policy and service delivery divisions;
- Change the licensure process for regional human service centers to require accreditation from a national accrediting body and licensing by DHS;
- Add crisis services to the continuum of services for individuals with serious and persistent mental illness;
- Change membership and role of advisory groups for human services centers;
- Allow designated behavioral health providers to furnish preventive diagnostic, therapeutic, rehabilitative, or palliative services to individuals eligible for medical assistance;
- Remove the designated location of a second state hospital for the mentally ill.

Change the Definition of Addiction Counseling: To include gambling, tobacco, nicotine, or other harmful substance or behavior, as defined in the Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 5th edition, text revision (2013), or a future edition adopted by the board.

State Hospital: The committee recommended a concurrent resolution to amend and reenact subsection 8 of Section 12 of Article IX of the Constitution of North Dakota to remove provisions requiring a state hospital to be located in Jamestown.

Tier System Definition for Mental Health Professionals: The committee recommended a bill to change statutory references for mental health professionals to a tiered system.

Health Services Committee: Chaired by Senator Judy Lee, recommended three bills to move forward into session. The first changes the dental loan repayment program to provide for a prorated payback of loan repayment funds if a dentist breaches the loan repayment contract. The second bill would allow for clinical supervision of behavioral health professionals by behavioral health professionals outside of their respective professions and to provide for a report to the Legislative Management; and the final bill would establish a loan forgiveness program for nursing faculty.

The committee made no recommendation related to its study of medicolegal death investigation in the state and how current best practices, including authorization, reporting, training, certification, and the use of information technology and toxicology, can improve death investigation systems in the state. The committee also made no recommendation related its study of the feasibility and desirability of UND acquiring the building that houses the UND Forensic Pathology Center

We expect several other health-care related initiatives to be introduced this session including:

Dental Midlevels: In 2015 a bill was introduced and defeated for a new licensure of dental professional called a dental therapist. The North Dakota Dental Association was strongly opposed to this new licensure, claiming that it would not help access and would allow dental care to be provided by lesser trained professionals. The health services committee studied it in great detail over the interim, and it is likely to be refiled in this session.

Health Care Provider Assault: In 2014, NDMA HOD adopted a resolution to support enhanced protection

What can NDMA members do? Contact local legislators before the session; Communicate concerns and issues back to NDMA; Keep apprised of legislative developments throughout the session - *www.ndmed.org*; Do grassroots lobbying with local legislators; Participate in the Doctor of the Day program; Participate in Physician Day at the Capitol on January 31, 2017, and give to NDMA PAC or PAC of your choice!

for healthcare workers assaulted on the job. In the 2015 Session, NDMA introduced a bill to increase the penalty for assaults against all health care providers. Presently, ND law only protects emergency room workers. The bill was defeated in the Senate. As with many issues, it sometimes takes more than one try to get a bill passed. Therefore, in the 2017 Session – NDMA, in partnership with ND Nurses Association and the ND Hospital Association, will re-introduce the bill with modifications – to appeal to more legislators.

Interstate Medical Licensing Compact: Has been adopted by 18 states, many of which surround North Dakota. To be eligible for expedited licensure, physicians must: possess a full and unrestricted license to practice medicine in a Compact state; possess specialty certification; have no discipline on any state medical license; not be under investigation by any licensing or law enforcement agency; have passed the USMLE or COMLEX (or equivalent) within 3 attempts and have successfully completed a residency. NDMA policy supports the Compact and several of the health systems would like to see this bill passed in North Dakota. It is likey to be introduced in the 2017 Session.

Scope of practice issues will likely come to the legislature, and NDMA will analyze and advocate on each issue separately as each proposal impacts the safety of patients and the quality of medical care.

What can NDMA members do? Contact local legislators before the session; Communicate concerns and issues back to NDMA; Keep apprised of legislative developments throughout the session – *www.ndmed.org*; Do grassroots lobbying with local legislators; Participate in the Doctor of the Day program; Participate in Physician Day at the Capitol on January 31, 2017 and give to NDMA PAC or PAC of your choice! If you see any issue that you would like to learn more about, please do not hesitate to contact Courtney Koebele.

Health Information Technology

Sheldon Wolf

The North Dakota Health Information Technology Advisory Committee (HITAC), a public-private partnership of healthcare stakeholders, in collaboration with ITD, is charged with expanding the secure exchange of health information in the State of North Dakota. To meet this charge, the HITAC has established the North Dakota Health Information Network (NDHIN).

Early this year, HITAC requested that the NDHIN complete a five-year business plan to identify where the NDHIN should go in the next five years and to ensure the project is providing a return on investment. To facilitate this work, we procured the services of the CedarBridge Group. As part of developing the business plan, the CedarBridge Group completed an environmental scan, a best practice brief, a future state brief, and a return on investment calculator. These deliverables assisted in the development of the five-year business plan for HITAC. More information on these deliverables can be found at: *www.nd.gov/itd/statewide-alliances/ndhealthit/resources/ndhin.*

The business plan proposes increasing the connections and information exchange amongst providers and with the NDHIN. These additional connections include completing connections with the hospitals, providers, and clinics, and to start building connections with chiropractors, optometrists, dentists, long-term care providers, behavioral health providers, local public health units, pharmacies, DME providers, and any other healthcare provider that provides medical care to North Dakota patients. In addition to the North Dakota providers, the business plan includes building connections with Federal and other State healthcare partners. Examples of these include the Veteran's Administration, Indian Health Services, Department of Defense, and other state health information exchanges like South Dakota, Minnesota, Arizona, etc. The goal of these connections is to ensure that information is shared between the federal and state partners and North Dakota providers, making the healthcare information available when needed most, at the time of care.

In addition to connecting the North Dakota providers and other state and federal business partners, the business plan includes the following statewide applications: Care coordination, data analytics and population health, statewide credentialing, and an advance directive repository. The advance directive repository is currently under development and should be available in early 2017.

We anticipate funding this initiative by accessing funds from the Centers for Medicare and Medicaid Service's (CMS) HIE infrastructure program. This allows state Medicaid agencies to access funds with a ten percent match, with the match being contributed by the stakeholders of the NDHIN. The five-year plan has an initial cost of $47 million dollars with an anticipated $7 million dollar match

The NDHIN is a statewide system that was initially funded with state and federal funds. Future funding will be through a public-private partnership of statewide stakeholders.

Additional information can be obtained at *www.ndhin.org.*

A School for the Twenty-First Century

News from the Dean of the UND SMHS

October 14, 2016, marked one of the more noteworthy events in the history of the University of North Dakota, the School of Medicine and Health Sciences, and North Dakota with the official opening of the new building, a nearly $124 million educational and research facility that was completed on-time and on-budget. The ribbon-cutting ceremony to officially open the new building occurred on that afternoon, and it was a truly memorable event. There was a standing-room only crowd of around 350 people present for the ribbon-cutting ceremony and for the gala celebration later that evening. I know that many members of the North Dakota Medical Association were in attendance (especially graduates of the School in milestone classes, including a 60-year graduate!), and I thank you all for attending. The special guest speaker at the evening celebration was Dr. Darrell Kirch, president and CEO of the Association of American Medical Colleges that represents all 145 medical schools in the United States. He presented a thoughtful address about the "Power of Community" that was especially appropriate in this time of national political discord. Dr. Kirch posited the notion that local communities—of learners, people like you who provide care, and donors—have the power to advance projects (like healthcare workforce development for North Dakota) that are too big and complicated for individuals to accomplish, and are not the focus or province of national agencies.

The School has long promoted the concept of small-group learning experiences, but we've advanced that idea considerably with the construction of eight physical learning communities in the new building that foster interprofessional and team-based learning—in essence, a community of learners. These learning communities are self-governing groups of about 100 students each composed of trainees in all of the health disciplines sponsored by the SMHS. So we have physical and occupational therapy, medical laboratory science, sports medicine, physician assistant, and medical students all housed together for an integrated learning experience. We believe that the active and interprofessional education that is occurring in these learning communities will better prepare our graduates for the rapidly changing world of clinical healthcare delivery that stresses team approaches to healthcare; obvious examples include accountable care organizations and medical homes that are becoming increasingly commonplace in the healthcare delivery enterprise. As I walk around the building, I see evidence of this team-based and collaborative approach everywhere; students often are clustered in small groups during and after hours tackling various educational projects. And having recently completed a variety of educational exercises on cardiovascular pathophysiology with the second-year medical students during their Block VI, I can attest to the effectiveness of the new space that permits, among other things, multiple small groups to sit and work together in a larger classroom.

North Dakota leads the nation in the fraction of physicians who are on the voluntary clinical faculty roster of a local medical school—in our state, two out of three of you from across the entire state are faculty members at the School of Medicine and Health Sciences.

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

A second vitally important community in support of the SMHS is that composed of donors. Why are private donations so important? They are needed to improve the student experience, largely through scholarship support to lower student debt. Even though our educational costs are among the lowest in the region and nation, our medical students used to have above-normal educational debt, reflecting the often more constrained financial resources our students have

compared with medical students elsewhere, resulting in the need for more borrowing. But through the generosity of our donors, we have been able to reduce their cumulative debt from well above to well below the national average. This is a wonderful example of a highly effective public-private partnership; the Legislature has provided a marvelous and functional new building and strong appropriated support for our programs, and the public has joined that effort by endeavoring to reduce student debt. To honor our especially generous donors, we have designated some three dozen named spaces in the building to recognize and acknowledge these gifts.

And the last critically important community for the School is composed of graduates and other concerned practitioners who through your dedication and altruism give back to the School and the healthcare enterprise by being voluntary clinical faculty members who teach our students for modest or no remuneration—a community of people who care. North Dakota leads the nation in the fraction of physicians who are on the voluntary clinical faculty roster of a local medical school—in our state, two out of three of you from across the entire state are faculty members at the School of Medicine and Health Sciences. The national average is about one in six, so you can see how dedicated you are to the education of the next generation of physicians. Thank you all! It would be impossible to train our students without your help and support, that's for sure.

The SMHS is one of 27 community-based medical schools in the United States, meaning that we don't own or operate our own hospital or hospital system. Instead, as you know, we partner with all of the larger hospitals and many of the smaller hospitals and clinics in the communities throughout the state to educate our students. I like to say that we are a community-based medical—and health sciences—school, and our community is all of North Dakota. And it is the active participation and support of the three communities outlined above—learning, caring practitioners, and donors—that have helped propel the School forward. Thanks to all the caring, dedicated, and forward-thinking people who have brought us to where we are. The future looks even brighter thanks to your efforts!

Make-A-Wish North Dakota: Transform Lives, One Wish at a Time

Billi Jo Zielinski

Imagination is powerful. It is the beginning of the Make-A-Wish® journey. From a child's imagination, all that we do, together, is made possible. But before any Make-A-Wish staff or volunteers get involved, it starts with you–the medical community. Thank you. You are there through the appointments, treatments, and most times to refer a child to our program so they can begin to imagine.

Along with your care, a wish come true helps children feel stronger, more energetic, more willing and able to battle their life-threatening medical conditions. As our chapter approaches the granting of our 800th wish, we celebrate imagination, how far we've come and how you can help us to reach every eligible child.

Our Beginnings

Make-A-Wish started in 1980 as a movement inspiring the nation, and five years later, a group of caring individuals founded the North Dakota chapter. Our first wish was granted to a 7-year-old boy named Christopher with leukemia who wished to watch movies in his St. Luke's hospital room. Through the generosity of a local video store, Christopher was able to watch movies on his new VCR – his wish came true with the imagination of wish granting volunteers. Since then, over 780 heartfelt wishes have been granted to children across the state.

Impact

The mission of Make-A-Wish is to grant the wishes of children with life-threatening medical conditions to enrich the human experience with hope, strength, and joy. When a wish is granted, a child replaces fear with confidence, anxiety with excitement, and sadness with optimism. A past wish impact study performed by Make-A-Wish America showed:

- A combined 89 percent of doctors, nurses and health professionals surveyed say they believe a wish experience can influence wish kids' physical health.
- Ninety-nine percent of parents reported that the wish experience gave their children increased feelings of happiness and 96 percent said that the wish experience strengthened their families.
- 81 percent of parents observe an increased willingness by their wish kids to comply with treatment protocols.

Dr. Nathan Kobrinsky from the Roger Maris Cancer Center attests to these statistics and says, "The Make-A-Wish experience bolsters their strength, the strength of their family, and it can be seen as part of the treatment."

We granted 40 wishes last year and we hope to grant wishes to 46 children fighting critical illnesses, but we can't do it without you. Our partnership is so important – when you invite families to be part of the Make-A-Wish experience, you are joining a community of people who are striving to improve children's lives by sparking their imagination and delivering strength.

Eligibility and Referral

A child with a life-threatening medical condition who has reached the age of 2 1/2 and is younger than 18 at the time of referral is potentially eligible for a wish. Every year, approximately 50 families in North Dakota learn their child is diagnosed with a life-threatening medical condition.

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

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

Make-A-Wish does not cold call the families of potentially eligible kids. We ask you to please exercise compassion and suggest to families that they contact us directly.

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

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

In fact, in December 2015, Keaton, a West Fargo boy with cystic fibrosis, had his wish granted to be Santa and deliver candy, milk and cookies and toys to children in the hospital. Keaton's life was transformed when he had the chance to live out his one true wish to be St. Nick for the day and give back to other ill children. Children with critical conditions only get a once-in-a-lifetime wish experience like Keaton's if they are informed by or referred by individuals like you.

When kids like Keaton smile, you'll smile—experience the power of joy when you help grant a wish for a child battling a critical illness.

For More Information

Additional information can be found on our website northdakota.wish.org or at our Secure Medical Wish Referral site, *md.wish.org*. Furthermore, you can email Kimi Lee, our Director of Program Services, at klee@northdakota.wish.org or by calling our office at 701-280-9474. Together, we can reach every eligible child in North Dakota.

Judgment on Life Expectancy at Issue in Medicare Fraud Case

By Troy Parks

Determining life expectancy is not an exact science, but over a million Americans each year who turn to hospice care depend on a physician's clinical judgment so they can live their remaining time in relative comfort. The Medicare hospice benefit, created in 1982, helps patients transition to end-of-life hospice care. A case before the 11th U.S. Circuit Court of Appeals is threatening physicians' ability to exercise their judgment.

At stake in United States of America v. GGNSC Administrative Services is this question: When can a physician's clinical judgment regarding a patient's life expectancy—based on the normal course of a terminal illness—be considered false under the False Claims Act?

In this case, the government alleges that a hospice care center violated the False Claims Act by billing Medicare for services that did not qualify for reimbursement.

Two conditions must be met for a patient's care to qualify for payment under the Medicare hospice benefit:

- A physician must certify that the patient's medical condition is such that it appears the patient has less than six months to live
- The medical record must support the physician's evaluation

The patients in question had the required physician certifications and their doctors testified that their medical records supported this evaluation. However, the government introduced testimony from another physician who claimed that the medical records did not support the certifications stating the patients had less than six months to live.

The trial court found that "something more" than a mere second opinion from another physician was needed to prove that the first doctor's terminal illness certification was false. On appeal, the government maintained that it only had to show that a physician disagreed with the certifying physicians as to the adequacy of the medical record, and it would be for the jury to determine who was telling the truth.

In defense of the hospice center physicians, the AMA and four hospice and palliative care organizations filed an amicus brief stating that for a physician's opinion to be deemed false, it must be proved that no reasonable physician could hold that opinion.

Clinical judgment or opinion?

"This case does not involve something as simple as a patient's weight or body temperature," said the brief filed by the AMA. "Nor does it involve something as comparatively straightforward as how to lower

a patient's cholesterol. Rather, this case involves something far more complicated."

When it comes to how long a patient is expected to live, the range of reasonable conclusions can be quite broad, the brief said. That is true for three reasons:

- Assessing a patient's life expectancy is a judgment about the future, and there is uncertainty in any prediction. The Medicare statute and regulations demand only that a prognosis be based on an illness' "normal course."
- Numerous factors may influence when a person will die, making a patient's life expectancy especially challenging to predict. That is why the Medicare statute and regulations ask only that physicians exercise their best "clinical judgment" in certifying that a patient has a six-month prognosis.
- Personal knowledge of a patient, especially information gleaned from face-to-face consultations, can be difficult to reduce to writing. Because that is the case, the determination of a physician reviewing only the written record—often years later—may well differ from the prognosis of a physician who actually saw the patient in person or consulted with clinical professionals who did. That is why the Medicare regulations require only that each certification be accompanied by documentation that "support[s]" the prognosis.

The text of the Medicare statute and regulations reflect "the fact that making medical prognostications of life expectancy is not always exact." In 2000, Congress amended the statute to clarify that certification of a patient as terminally ill "shall be based on the physician's or medical director's clinical judgment."

Clinical judgment means trusting the discretion of a certified professional and trusting that a physician is making a decision to the best of his or her ability and in the best interest of the patient. Patients in hospice care will often live longer than six months after being deemed "terminally ill."

If the testimony of a single physician who did not have face-to-face consultations with the patients, but rather formed a judgment based solely on written documents is allowed to overturn the testimony of several physicians who did meet with the patients and created the written documents, hospice benefits for future terminally ill patients could be denied.

Substance Exposed Newborns: An Introduction to Solutions

Pamela Sagness
Behavioral Health Division Director

Prenatal exposure to alcohol, tobacco, and illicit drugs has the potential to cause a wide spectrum of physical, emotional, and developmental problems for these infants. Nationally each year an estimated 400,000–440,000 infants (10–11% of all births) are affected by prenatal alcohol or illicit drug exposure. In 2013, 795 children were diagnosed with Fetal Alcohol Spectrum Disorder in North Dakota. FASD is more prevalent than Down Syndrome, muscular dystrophy, and is as common as autism spectrum disorder.[1] The harm caused to the child can be significant and long-lasting, especially if the exposure is not detected and the effects are not treated as soon as possible.[2]

Nationally each year an estimated 400,000-440,000 infants (10-11% of all births) are affected by prenatal alcohol or illicit drug exposure. In 2013, 795 children were diagnosed with Fetal Alcohol Spectrum Disorder in North Dakota.

Following a multi-year review and analysis of existing policies and practices, the National Center on Substance Abuse and Child Welfare developed a five-point intervention framework to address the system surrounding substance exposed newborns. This framework serves as a comprehensive model that identifies five major timeframes when intervention in the life of an infant can help reduce the potential harm of prenatal substance exposure. The framework illustrates that birth is one of many opportunities to positively affect intervention outcomes. Therefore, it is important to understand the extent of those opportunities and which interventions are most needed and most likely to be effective at each point in time.

Five Point Intervention Framework Overview

Including excerpt recommendations from the North Dakota Task Force on Substance Exposed Newborns report to ND Legislative Management[3]

1. **Pre-pregnancy:** During this time, interventions can include promoting awareness among women of child-bearing age and their family members of the effects that prenatal substance use can have on infants.

Recommendations:

- Develop education materials and an awareness campaign to educate women of childbearing age, as well as their significant others and families, about the dangers of substance use/abuse during pregnancy.
- Health care providers should be informed of and encouraged to refer patients of childbearing age with substance abuse concerns to addiction treatment resources.

2. **Prenatal:** During this time, health care providers have the opportunity to screen pregnant women for substance use as part of routine prenatal care and to make referrals that facilitate access to treatment and related services for the women who need these services.

Recommendations:

- Medical providers who provide services to pregnant women should understand their responsibilities surrounding testing, referral, follow-up and reporting.
- Medical providers should develop consistent

protocols for universal screening and testing of pregnant women.

- Medical offices that provide care to pregnant women should develop protocols to identify patients who might be substance users/abusers and schedule appointments for them early in their pregnancies so they can receive information on the dangers of substance use/abuse as soon as possible.
- Medical providers should provide best practice care to patients who are substance users during pregnancy (i.e., create a standard of care for pregnant mothers with an opioid use disorder be prescribed buprenorphine).

3. Birth: Interventions during this time include health care providers testing newborns for prenatal substance exposure at the time of delivery.

Recommendation:

- Medical providers should develop consistent protocols for universal screening and testing of newborns.

4. Neonatal: During this time, health care providers can conduct a developmental assessment of the newborn and ensure access to services for the newborn as well as the family.

Recommendations:

- Hospitals and social service agencies should partner in the development of plans of safe care for each newborn born with prenatal exposure to substances, prior to discharge from the hospital following the birth.
- Parents and caregivers (including foster parents) should receive training and educational materials on best practices for caring for a newborn with prenatal exposure to substances prior to discharge.

5. Throughout childhood and adolescence: During this time, interventions include the ongoing provision of coordinated services for both child and family.

Recommendation:

- County social services and direct service providers need training so they can better inform foster parents about care for children born exposed to substances. Social workers also need appropriate education materials and training presentations that they can offer to foster parents.

The ND Task Force on Substance Exposed Newborns, 2016 Summary of Recommendations can be found here: *www.parentslead.org/sites/default/files/NDTaskForce-SubstanceExposedNewborns.pdf*

This five-point intervention framework highlights opportunities for cross-system collaboration and policy development at each critical point in time, from pre-pregnancy throughout an infant's early years. The framework also integrates recommendations for best practices related to outreach, engagement, treatment, and support for mothers and their infants along the five-point continuum. The framework shows that no single system has the necessary resources, information, or influence needed to adequately serve this vulnerable mother–infant dyad and other involved family members who are likely to need services. All those who have a role in improving outcomes for such families need to collaborate in order to put the necessary policies and practices in place. These collaborations can set the stage for maternal recovery from substance use disorders, child safety, and the well-being of all those involved.

Without a comprehensive coordinated response that includes child welfare and health care, including obstetrics, pediatrics, substance abuse treatment, and mental health professionals, families are not well-served. Cross-system initiatives lead to better results by facilitating better communication, clearly defining the roles of the various professionals who serve these families, and maximizing the resources of multiple stakeholders who have a vested interest in accomplishing shared goals.[4]

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1. *Burd, PhD, 2016. A Report to the North Dakota Task Force on Substance Exposed Newborns: From North Dakota Fetal Alcohol Syndrome Center.*
2. *https://www.ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf*
3. *Senate Bill 2367 in the sixty-fourth Legislative Assembly created a task force on substance exposed newborns "for the purpose of researching the impact of substance abuse and neonatal withdrawal syndrome, evaluating effective strategies for treatment and prevention and providing policy recommendations."*
4. *https://www.ncsacw.samhsa.gov/files/Collaborative_Approach_508.pdf*

Partial Filling of Schedule II Prescriptions

Mark Hardy, PharmD
Executive Director
North Dakota Board of Pharmacy

In September 2016 the Board of Pharmacy sent out a memo to all the pharmacies across the state informing them of recent federal law changes relative to partial filling of Schedule II medications. Below is the context of the memo. This certainly has potential opportunities for practitioners prescribing controlled substances as well.

In July 2016, in an effort to address the prescription opioid abuse crisis, the Comprehensive Addiction and Recovery Act of 2016 was signed into law.

One of the provisions of this act provides for partial filling of Schedule II prescriptions. Previously, the partial filling of a Schedule II prescription was only permissible if the pharmacist was not able to provide the full quantity prescribed at the time of the filling, with the remainder filled within 72 hours. Partial filling had been allowed for nursing home patients in a nursing home setting or under hospice care (for up to 60 days).

The Act specifically amends 21 United States Code §829 by adding subsection (f), which allows for the partial filling of a Schedule II prescription if the following conditions are met:

- It is not prohibited by state law;
- The prescription is written and filled in accordance with federal and state law;
- The partial fill is requested by the patient or the practitioner who wrote the prescription and;
- The total quantity dispensed in all partial fillings does not exceed the total quantity prescribed.

The Act also provides that the remaining portion of a partially filled Schedule II prescription may be filled not later than 30 days after the date on which the prescription was written. However, if the partial filling of a Schedule II is the result of an emergency situation oral prescription, the pre-existing partial fill timeframe of 72 hours after the prescription was issued remains. There is no prohibition on partial fill of Schedule II prescriptions in North Dakota laws and rules.

This federal law change allowing partial fill of Schedule II prescriptions was meant to create opportunities to decrease the amount of unnecessary, unwanted and unused prescription opioid medications. However, this law change is applicable for ALL Schedule II prescriptions. We feel like this new provision allows medical professionals an opportunity to work with greater flexibility to patients in limiting the amount of Schedule II medications that we dispense in certain circumstances. An example being; a patient with a minor surgical procedure obtaining a partial fill of Vicodin to limit the amount of opioids initially dispensed; with the remaining amount available to have filled should it become necessary. This also has opportunities as third-parties look to design strategies, like ND Medicaid, to limit the amount of medication that may be received on the first partial fill, while if appropriate, having the remaining quantity dispensed within thirty days.

As always, it is important to discuss opportunities to utilize this expanded authority with your fellow medical professionals and how this may be useful in the care of your patients, with the goal of limiting the amount of unwanted, unused, unnecessary opioids and other Schedule II medications in North Dakota households.

Leftover prescription medications being diverted continues to be a major issue with drug overdoses and abuse. Limiting the amount of unused controlled substances in the medicine cabinets will also limit the opportunity for our citizens, youth or others, to divert them for illicit use.

Drug Take Back Update

The Board of Pharmacy has now provided controlled substance drug disposal containers to over 75 pharmacies across the state. We encourage our licensees and registrants to educate the public about those opportunities during their work in a pharmacy and in their day-to-day lives.

Again, getting those medications out of the homes and properly disposed is a very important component in tackling the epidemic we are experiencing with drugs in our state.

UND School of Medicine and Health Sciences - Teddy Bear Clinic

On November 3, 2016, one hundred Grand Forks kindergarten students brought their teddy bears to UND's brand new medical school for a checkup during the third annual Teddy Bear Clinic. This yearly event is hosted by a large contingent of University of North Dakota students, including medical, occupational and physical therapy; nutrition and dietetics; and nursing. The kindergartners work with North Dakota's future health professionals towards a common goal of making Teddy feel better. Kindergartners experience fun, interactive lessons on health and wellness with their very own teddy bear, or other stuffed animal of their choice. The children learn everything from hand-washing, to good dental hygiene, to healthy eating. They are partnered with a medical student to perform an examination which may include Teddy going through an x-ray machine and even surgery. Firefighters from the Grand Forks Fire Department were on hand as well to emphasize safe practices around the home.

Above, Hasanga Samaraweera, MS IV, one of the program founders, with Joshua Wynne, MD, Dean UND SMHS

The clinic is a great example of community commitment and attention to population health principles demonstrated by the UND students. The Teddy Bear Clinic never would have gotten off the ground without the financial support of the NDMA Districts.

North Dakota Professional Health Program

Tammy King, LSW, MS, CRC
Executive Director
North Dakota Professional Health Program

The North Dakota Professional Health Program (NDPHP) is a confidential resource that assists with the identification, intervention, referral, monitoring and recovery of physicians, physician assistants, and medical and physician assistant students who may be affected by substance use or mental health disorders. Our philosophy includes care of the whole person, focusing on the special needs of health care professionals. Early intervention and evaluation offer the best opportunity for a successful outcome and preventing the health condition from interfering with medical practice.

The program, once managed by the ND Board of Medicine (NDBOM), is now operated independently as a non-profit program. Our mission is: "To facilitate the rehabilitation and monitor the recovery of health care providers who have physical or mental illnesses that may result in impairment." By improving the health of those afflicted by substance use or mental health disorders, we believe we can improve their well-being and effectiveness, as well as improve the quality of patient care and safety. We do this by offering referrals to high quality, evidence-based treatment programs, and backed up by providing confidential support and advocacy.

The program is designed to encourage licensees and students to seek treatment for substance use and/or mental health disorders before their impairment harms a patient, damages their careers, or results in disciplinary action by the Board.

The program is designed to encourage licensees and students to seek treatment for substance use and/or mental health disorders before their impairment harms a patient, damages their careers, or results in disciplinary action by the Board. By monitoring progress and compliance in the program, NDPHP is able to advocate for clients with employers, insurance companies, specialty boards, state licensing bureaus and colleges. Clients enrolled in our programs are exempt from the requirement to report substance use disorders and mental health disease to the board at the time of license renewal.

The NDPHP accepts referrals from any source including self, physician peers, professional colleagues, medical staffs, office staffs, regulatory agencies, attorneys, treatment centers, family and friends. NDPHP protects the confidentiality and anonymity of program participants and referral sources.

We would welcome the opportunity to spread the word about the program by speaking at staff meetings or other events or by being a vendor at conferences. For detailed information about the NDPHP and how it works, please go to *www.ndphp.org* or call us at (701) 751-5090.

POLST Update for North Dakota

In 2010, the North Dakota Medical Association urged North Dakota physicians and healthcare providers across all healthcare settings to consider Physician Orders for Life-Sustaining Treatment (POLST) elements. A workgroup was developed creating a North Dakota Advance Care Planning Initiative now known as Honoring Choices® North Dakota (HCND). The vision of HCND is: "to create a culture across ND where continuous (on-going) advance care planning (ACP) is the standard of care and every individual's informed preferences for care are documented and upheld."

Nancy Joyner, RN, MS
President, Honoring Choices® North Dakota

Kristina Schlecht, MD,
Associate Director, UND Center for Family Medicine-Minot, NDMA Ethics Commission Chair

Defining Advance Care Planning and the Role of POLST

Advance care planning is "a person-centered, ongoing process of communication that facilitates an individual's understanding, reflection and discussion of their goals, values and preferences for future healthcare decisions" (Respecting Choices®, Gunderson Health System). HCND recognizes ACP as a process. It starts with a conversation, which then is documented with a healthcare directive, then translated into medical orders.

Why POLST?

The POLST paradigm improves the quality of care for patients who are seriously ill or frail by creating a voluntary system that elicits, documents and honors patient medical treatment wishes through portable medical orders. A Physician Orders for Life-Sustaining Treatment Form is completed based on conversations between patients and healthcare professionals about goals of care, quality of life, diagnosis, prognosis and treatment options.

Clinical experience and research show healthcare directives are not sufficient alone to assure that their preferences for treatment will be honored unless a POLST Form is also completed (POLST.org website).

Who Should Have a POLST?

POLST is not for everyone; only patients with serious illnesses or frailty should have a POLST Form. For these patients, their current health status indicates the need for standing medical orders for emergent medical care. For healthy patients, an advance directive is an appropriate tool for making future end-of-life care wishes known to loved ones.

To determine whether a POLST Form should be encouraged, healthcare professionals should ask themselves, "Would I be surprised if this person died in the next year?" If the answer is "No, I would not be surprised," then a POLST Form is appropriate.

Comparing POLST Form to Healthcare Directive

	Healthcare Directive	POLST
Population	All adults >18 y.o.	Any age, serious illness, at end of life or frailty
Timeframe	Future care/future conditions	Current care/current conditions
Where Completed	Any setting, not necessarily medical	Medical setting
Resulting Product	Healthcare agent appointed and/or statement of preferences	Medical orders based on shared decision-making
Healthcare Agent Role	Cannot complete	Can consent if patient lacks capacity
EMS Role	Does not guide EMS	Guides EMS as a medical order
Portability	Patient/family responsibility	Healthcare professional responsibility
Periodic Review	Patient/family responsibility	Healthcare professional responsibility

Status of POLST in North Dakota

Over the past four years, a workgroup, under the direction of HCND revised the original 2007 POLST Form to create a statewide form meeting the requirements of the National POLST Paradigm Task Force (NPPTF). The new 2016 form is complete and awaiting education and placement on the Honoring Choices® North Dakota website. It is the intent to have the POLST Form available on the website by mid-January, 2017.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

North Dakota POLST: Physician Orders for Life Sustaining Treatment

Physician Orders for Life-Sustaining Treatment (POLST)

FIRST follow these orders, THEN Call the appropriate medical contact. These medical orders are based on the patient's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Patient's Last Name

Patient's First Name/Middle Initial

Patient's Date of Birth

A Check One

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **CPR/ATTEMPT RESUSCITATION** ☐ **DNR/DO NOT ATTEMPT RESUSCITATION** (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B and C.

B Check One

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

Comfort Measures always provided regardless of level of care chosen.

☐ **COMFORT MEASURES ONLY -** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.

- ☐ Avoid calling 911, call _____ instead (e.g. hospice)
- ☐ If possible, do not transport to ER (when patient can be made comfortable at residence)
- ☐ If possible, do not admit to the hospital from ER (e.g. when patient can be made comfortable at residence)

☐ **LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS -** Provide interventions aimed at treatment of new or reversible illness/injury or non-life threatening chronic conditions. Duration of invasive or uncomfortable interventions should generally be limited (Avoid intensive care).

☐ **FULL TREATMENT -** Use all appropriate medical and surgical interventions as indicated to support life. Transfer to hospital if indicated. Includes intensive care.

Additional Orders: (e.g. dialysis, etc.)

C Check One

Artificially Administered Fluids and Nutrition:

- ☒ Always offer food/fluids by mouth if feasible and desired.
- ☐ No artificial nutrition by tube.
- ☐ Defined trial period of artificial nutrition by tube.
- ☐ Artificial nutrition and hydration unless it provides no benefit.
- ☐ Long-term artificial nutrition by tube.

Additional Orders:

D Must fill out

DOCUMENTATION OF DISCUSSION (Required)

☐ Patient (if patient has capacity) If patient lacks capacity:

- ☐ A Health Care Directive
- ☐ Health Care Agent
- ☐ Person legally authorized to provide informed consent (See reverse)

Health Care Agent/Legal Representative Name — Relationship

E

PATIENT or Health Care Agent/Legal Representative (Required)

Signature — Date of signature

F

ATTESTATION OF MD/APRN/PA (Required) By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's current medical condition and preferences.

Print Name of MD/APRN/PA Name — Signer Phone Number — Signer License Number

MD/APRN/PA Signature: required — Date: required

2016 North Dakota POLST SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED **1**

A Recap of NDMA's 129th Annual Meeting

The 129th Annual Meeting of the NDMA House of Delegates concluded its business Friday, October 7, at the Hilton Garden Inn in Fargo, electing officers and adopting resolutions.

The night prior to the meeting, the NDMA PAC held a social at the Würst Bier Hall. Representative Kevin Cramer attended the PAC event to receive a contribution from AMPAC and addressed the attendees. Our PAC does important work to further the advocacy and networking efforts of NDMA. Thank you to all our supporters!

Congressman Kevin Cramer with Fadel Nammour, MD at the NDMA PAC social on October 6 at the Würst Bier Hall in Fargo

Joshua C. Ranum, MD, NDMA Speaker of the House, convened the House of Delegates and reviewed the presented resolutions; all three resolutions were adopted and no new resolutions were introduced on the floor: Resolution 1.) Support further education on childhood immunizations to minimize non-medical exemptions, by working with the Department of Health and Department of Public Instruction; Resolution 2.) Oppose Measure 5 - Medical Marijuana, on the ballot on November 8, 2016; and Resolution 3.) Move forward to study the NDMA governance, in order to

Congressman Kevin Cramer addressing the crowd at the NDMA PAC social in Fargo

encourage greater participation from membership. Dr. Ranum also announced the slate of officers nominated by the districts, which was accepted by the House of Delegates. The 2016 executive officers are: **Debra A. Geier** of Jamestown, President; **Fadel E. Nammour** of Fargo, Vice President and Council Chair; **Misty K. Anderson** of Valley City, Secretary-Treasurer; and **Joshua C. Ranum** of Hettinger, Speaker of the House.

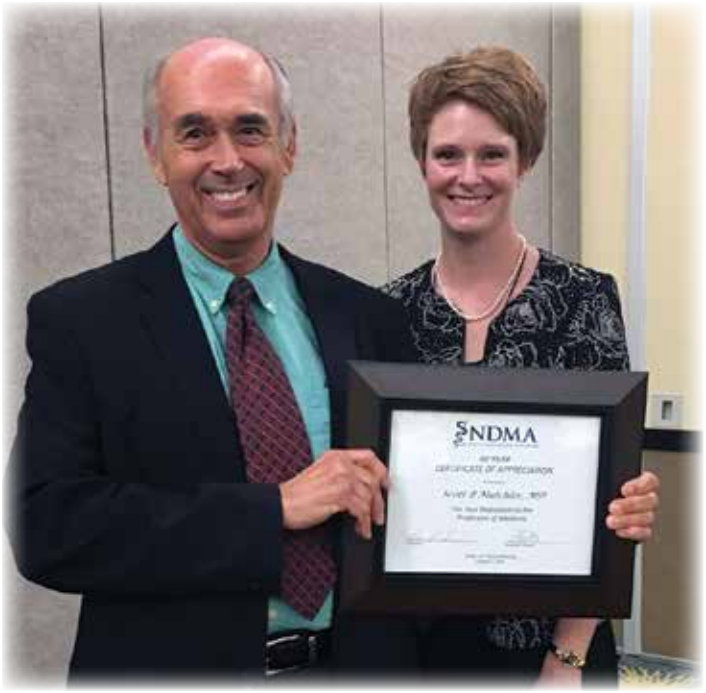
NDMA officers from L to R: Fadel Nammour, MD; Misty Anderson, DO; Debra Geier, MD; and Joshua Ranum, MD

In addition to House business, University of North Dakota School of Medicine and Health Sciences (UND SMHS) **Dean Joshua Wynne** presented an update on the brand-new School of Medicine building, and the progress on the Healthcare Workforce Initiative. **Richard Deem**, senior vice president of the American Medical Association (AMA) Advocacy Group presented a summary of MACRA and what AMA is doing to help physicians with this new payment system. **Julie Rickert**, PsyD, a clinical psychologist and an Associate Professor at the UND SMHS, presented on identifying risks of physicians neglecting their own well-being and provided strategies to engage physicians in appropriate self-care.

A panel on the opioid epidemic featuring: **Mark Hardy**, Pharm D, executive director with the North Dakota Board of Pharmacy; **Duane Houdek**, JD, executive secretary, North Dakota Board of Medicine; Special Agent, **Steve Gilpin** with the North Dakota Bureau of Criminal Investigation, and **Manuel Colon**, MD, MBA, CPE - Chair, Department of Pain Management, Sanford Health, Fargo discussed the increase in opioid cases in the state.

Lieutenant Governor candidate **Joan Heckaman**, and congressional candidates **Kevin Cramer** and **Chase Iron Eyes** spoke on campaign issues and answered questions.

At the annual lunch and awards presentation the NDMA tradition was observed of honoring those physicians who have achieved at least 40 years of service to the medical community upon graduation from medical school (1976). They are:



NDMA President Debra Geier, MD with award recipient Scott Mutchler, MD

Michael S. Briggs, MD, Fargo
Charles P. Dahl, MD, Bismarck
John A. Erickstad, MD, Bismarck
Larry O. Halvorson, MD Grand Forks
Donald B. Jenny, MD, Chapel Hill, NC
Larry E. Johnson, MD, Jamestown
Robert A. Johnson, MD, Grand Forks
Nathan L. Kobrinsky, MD, Fargo
Lawrence H. Licht, MD, Wahpeton
Scott B. Mutchler, MD, Fargo
James W. Nagle, MD, Fargo
James H. Olson, MD, Williston
Bruce G. Pitts, MD, Fargo
Ronald D. Tello, MD, Bismarck
Charles R. Volk, MD, Bismarck
Peter L. White, MD, Bismarck

Scott Mutchler, MD, was present to accept his certificate.

Julie Blehm Recognized for Community and Professional Service

Julie Blehm, MD, was awarded the North Dakota Medical Association's Physician Community and Professional Services Award. Dr. Blehm was nominated by Dr. James Brosseau, who presented her with the award.

Dr. Blehm has served in many different capacities within health care delivery in North Dakota. Her esteemed career has given her experience as a practicing physician at walk-in clinics, an emergency room, and a Veteran's home. Dr. Blehm honed her medicinal skills as an Associate Professor and then Associate Dean at the University of North Dakota School of Medicine and Health Sciences, a principal clinical coordinator at North Dakota Healthcare Review, Inc., Director of Chronic Disease Management and then Managing Physician Partner at Sanford Health, as well as Director of the Internal Medicine Residency Outpatient Clinic. Dr. Blehm is the current Senior Medical Director at Blue Cross Blue Shield of North Dakota.

Dr. Blehm is a diplomat for the Board of Internal Medicine, former Governor of the American College of Physicians (North Dakota Chapter) and currently serves on their Board of Governors. She has been involved with many other organizations and committees, but despite her impressive education, employment, publications, and leadership experiences, by far her most outstanding accomplishments shine through her work with each community she has resided within. Her passions and talents are wide-reaching, which more than qualifies her for this award and the dozens of other accolades she has received throughout her career. Truly, Dr. Blehm is not only dedicated to the practice of medicine, but also to the patients and public that she serves, in and out of a clinical setting.

NDMA Community and Professional Service Award recipient Julie Blehm, MD, with James Brosseau, MD

Joyce Sayler Recognized as Friend of Medicine

Joyce Sayler, RN, was recognized with the North Dakota Medical Association's Friend of Medicine award. Joyce was nominated by Fadel Nammour, MD, who presented the award to Joyce. 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."

Joyce Sayler has been an invaluable member of the public health professionals in Western North Dakota since graduating from the Bismarck Hospital School of Nursing

NDMA President Debra Geier addressing the reference committee during the NDMA House of Delegates (pictured L to R) Debra Geier, MD; Shari Orser, MD; Steve Strinden, MD; and Dennis Wolf, MD

NDMA Friend of Medicine Award recipient, Joyce Sayler, RN, with Fadel Nammour, MD

in 1975. In 2007 Joyce started with the ND Department of Health serving as the comprehensive Cancer Program Coordinator and she continues in that position today. In that position, Joyce facilitates the implementation of the North Dakota Cancer Plan by the statewide North Dakota Cancer Coalition.

Joyce has nearly forty years of experience working in rural health care settings and in public health. Most recently, Joyce has been instrumental in her role in the 80% by 2018 Campaign and the North Dakota Colorectal Roundtable, a statewide coalition of organizations dedicated to reducing the incidence of and mortality from colorectal cancer in our state through coordinated leadership and strategic planning.

The Friend of Medicine award is our way of recognizing those accomplishments and saying "thank you."

The NDMA Annual Meeting continues to be a source of education, fellowship, and networking. We hope you join us at our next gathering. We are working on 2017's Annual Meeting venue in Grand Forks which is set for October 6, 2017. Mark your calendars now and stay tuned for updates and information!

L to R: Elizabeth Faust, MD; Julie Blehm, MD; and Kim Krohn, MD, at the NDMA awards luncheon

Physician and Hospital Day at the Capitol
JANUARY 31, 2017

The North Dakota Medical Association is pleased to once again co-sponsor Physician, Hospital, and EMS Day at the North Dakota Legislature in Memorial Hall on Tuesday, January 31st, from 9 a.m. - 4 p.m. This is a great opportunity to get to know your local legislators.

We will provide a boxed lunch and legislators will be invited to the lunch, creating a great opportunity for physicians to connect with lawmakers and converse about healthcare issues or specific bills.

Wear your white coat and join us on Tuesday, January 31st, at the ND State Capitol in Bismarck.

RSVP by calling the NDMA office at 701-223-9475, or email staff@ndmed.com

NDMA Doctor of the Day at the Capitol

Volunteers are needed for the 2017 NDMA Doctor of the Day Program which begins on January 9, 2017, and continues through April. This is an excellent opportunity for you to observe the 2017 North Dakota Legislative Assembly in action and get connected. NDMA members wishing to sign up to serve as Doctor of the Day may do so at any time on the NDMA website, or by calling the NDMA office at 701-223-9475.

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

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

Lashing Out

How compassion fatigue can contribute to disruptive behavior

Michelle Kinner, RN, MSN,JD, CPHRM
Senior Risk and Patient Safety Consultant MMIC
Michelle.Kinneer@MMICgroup.com

A clinician is sitting at a kiosk charting her morning notes when a coworker approaches and asks a question. The clinician does not answer because, for personal reasons not related to the workplace, she is not speaking to that coworker.

A technician is overheard sharing an off-color joke in the hallway with another team member.

A nurse calls a physician for admission orders on her patient. The physician yells and curses at the nurse, complaining that the patient has been waiting on the unit for three hours, then hangs up the phone. The nurse calls back and informs the physician that she has only been on duty for an hour, and that orders are still needed for their patient. After three similar phones calls, the nurse finally receives admission orders.

What do these scenarios have in common? They are all examples of disruptive employee behavior – and unfortunately, these kinds of incidents occur regularly in hospitals, long-term care facilities and medical offices across the country.

"Disruptive behavior" is defined as any negative or inappropriate behavior in the workplace, including bullying, crude comments or jokes, the silent treatment, physical harassment and much more. Such negativity takes an obvious toll on both team members and patients. Facilities may suffer from increased turnover rates, employee dissatisfaction or reduced performance. In health care settings where such behavior occurs, patients may literally be at an increased risk of suffering medical errors and adverse outcomes. Patient satisfaction scores may take a downward spiral, affecting the financial status of the institution

What causes disruptive behavior?

The manner in which institutions respond to incidents of disruptive behavior may actually increase the likelihood of such incidents. For example, when health care leaders do not take swift, decisive action against complaints of disruptive behaviors, that inaction can serve as a green light – to the original offender and to others – to continue the behavior.

The stressful nature of the health care workplace can contribute to the frequency of disruptive behaviors.

Exacerbating this is the inherent complexity of the health care workplace, changing models of care, and revenue changes over time, leading to increased workplace stress. These and other stressors can lead health care professionals to depression, substance abuse, fatigue and burnout – all of which can be causative in disruptive behavior.

The personal costs of caring

When we consider the term "fatigue," we need to go beyond the simplistic definition of physical weariness and consider "compassion fatigue," which is a pronounced change in the ability to feel empathy due to a profound physical and emotional exhaustion.

In 1995, Charles Figley described compassion fatigue as the cost of caring for others. In the medical field, we care for those who have experienced trauma or who are suffering. Sadly, though perhaps understandably, witnessing frequent traumatic events can take a toll on the best of health care professionals.

Some authors have linked compassion fatigue to the personal cost of providing care to others. Many studies have linked burnout and employee dissatisfaction to compassion fatigue. Taken a step further, an argument can be made that compassion fatigue is at the very heart of many incidents of disruptive behavior we have seen in health care.

Finding balance

One way to reduce the development of compassion fatigue is for health care professionals to take time for themselves. Put another way, employees should strive to maintain a balance between their work and their personal lives.

Methods for achieving such balance include exercise, meditation or yoga. Adequate sleep and good nutritional habits can also aid in coping with the day-to-day grind of the health care setting. There are out-of-the-box methods as well: One nurse purchases a bouquet of flowers after any patient death or serious trauma in her department, a practice that she has found very helpful in maintaining work-life separation and balance.

How can our organizations help our team members and clinicians? We should train the entire team on the different types of disruptive behavior, methods to address their occurrence and facility policies regarding such behavior. Team members should be made to feel safe reporting disruptive behavior, and each facility should have processes in place to address incidents head-on. Facilities should also support a non-punitive environment for reporting of occurrences.

Support programs, such as employee assistance programs, should be available for clinicians. Administrators can offer coaching and counseling to both offender and victim in these situations. In such cases, leaders may need to facilitate a conversation or mediation, or perhaps adjust work assignments for team members.

MMIC offers a variety of resources to support health and well-being. Through its public portal, MMIC offers a Well-being Center* with resources ranging from suggested books, videos and conferences, to information on recognizing stress and burnout. There is even a link to the Canadian Mental Health Association's Work/Life Balance Quiz, a very useful tool for any health care professional. MMIC clients can also access a Provider Well-being Stress & Burnout self assessment through the client portal.

In addition, MMIC offers a Bundled Solution that focuses on preventing workplace violence. Resources in this Bundled Solution include sample policies, educational materials and toolkits. If you have questions about accessing any of the resources available from MMIC, please contact your Senior Risk and Patient Safety Consultant.

Regardless of our specialty or work environment in health care, our well-being and health is imperative. We should address disruptive behaviors, either in ourselves or in our coworkers, because our patients depend on us to be healthy, compassionate caregivers.

**MMICgroup.com/resources/well-being-center*

Resources

Berman-Kishony, T and Shvarts, S. Universal versus tailored solutions for alleviating disruptive behaviors in hospitals. Israel Journal of Health Policy Research. 2015;4(26):1-12. doi: 10.1186/s13584-015-0018-7.

Stamm B. Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators. Baltimore, MD: The Sidran Press; 1996.

We understand the art of healing and the science of avoiding risk.

Medical liability and more.

At MMIC, medical liability is just the beginning. For more than 35 years, we've worked directly with physicians and developed a deep understanding of the risks involved with practicing medicine. We're there for those who are always there, drawing on a wide range of clinical data, insights and best practices from medical experts to help care teams deliver better care. To learn more visit **MMICgroup.com**.

MMIC

ND Physician

North Dakota Medical Association
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2017 Events Calendar

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

January 10
NDMA Council Meeting
Bismarck, ND

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

January 30
NDMA Council/Legislation Commission Meeting
Bismarck, ND

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

February 1-2
Altru Health Fair at the Capitol
Bismarck, ND

March 14
NDMA Council/Legislation Commission Meeting
Bismarck, ND

March 24
ND Board of Medicine Meeting
Bismarck, ND

April 6
Honoring Choices Day at the Capitol
Bismarck, ND

April 22
ND Society of Orthopaedic Surgeons Annual Meeting
Radisson Hotel, Bismarck, ND

April 28-29
ND-SD ACS Annual Meeting
Cambria Suites, West Fargo, ND

May 9
NDMA Council Meeting
Bismarck, ND

May 14
UND SMHS Graduation
Grand Forks, ND

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