



Physician

June 2015



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.

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

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2015 Legislative Summary 14

Physician Advocate	3	NDMA Launches New Website	22
NDMA in Action.....	6	NDMA Awards	24
News from UND SMHS.....	8	The Fresh Air Report	26
Annual AMA Meeting.....	10	UND SMHS Recognizes Volunteer Faculty	30
An AMA Viewpoint.....	13		

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Physician Advocate

Physician Satisfaction

We will continue our discussion about physician satisfaction begun in the last issue of *ND Physician*. As the RAND Corporation began to look at physician satisfaction, the effect of electronic health records (EHRs) demonstrated a stunning impact and the study was rewritten to look more intently at the impact of the electronic health record.

When physicians perceive themselves as providing high quality care, they are more satisfied. Conversely, obstacles to providing high-quality care are major sources of professional dissatisfaction. Ergo- let's talk EHRs.

ELECTRONIC HEALTH RECORD

The EHR represents a unique and vexing challenge to professional satisfaction. Few other industries are exposed to universal and substantial incentives to adopt such a specific and highly regulated form of technology, a technology that has not yet matured. Nearly all physicians see the benefits of EHRs and believe in the "promise of EHRs". On the other hand, physicians cannot buy, install, and use a promise to help them deliver patient care. The current state of EHR technology appears to significantly worsen professional satisfaction for many physicians; sometimes in ways that raise concerns about effects on patient care. The RAND study found that many EHR vendors are preoccupied with backlogged implementation and selling current products and that this has resulted in a neglect of development priorities that could improve usability.

The AMA sees three aims in using EHR: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.

How to effectively use EHRs is an ongoing concern for physicians. The design and implementation of EHRs

do not align with the cognitive or work flow requirements and/or preferences of physicians within and across specialties and settings. One clinical issue is that EHRs were designed to support transaction processing and billing and do not adequately provide cognitive support for health care providers and for patients and for family caregivers.

The AMA sees three aims in using EHR: improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.

EHRs have important effects on physician professional satisfaction, both positive and negative. In the RAND study, satisfaction with EHRs was an independent predictor of physicians' overall professional satisfaction and having more EHR functions (reminders, alerts, and messaging) was associated with lower professional satisfaction. No correlation was found between overall satisfaction and the length of time since EHR installation. Here are some of the positives to EHRs that physicians cited:

- **Concept:** Physicians approve of EHRs in concept, describing better ability to remotely access patient information and improvements in quality of care. We also recognize the potential for EHRs to further improve both patient care and professional satisfaction in the future as the technology improves.
- **Data Access:** Physicians find that EHRs improve access to patient data, both in health care settings and at home. This improved access is seen as improving patient care and professional satisfaction.



Steven P. Strinden, MD

There are also lifestyle advantages noted with the ability to access patient information from home.

- **Disease Control:** Physicians describe the improvement in ability to provide guideline based care using EHRs. It makes tracking patient markers of disease control over time easier and accurate.
- **Enhanced Communication:** EHRs enhance communication through the medical record itself, by facilitating access to other providers' notes, eliminating illegible handwriting, and utilization of messaging applications. This with the caveat that it works for physicians using the same system.

But every rose has its thorn. Here are the negatives:

For most physicians, the current state of EHR technology appears to worsen physician professional satisfaction significantly in a number of ways. Poor usability, time consuming data entry, interference with 'face to face care,' inefficient and less fulfilling work content, inability to exchange information between providers, and degradation of clinical documentation are prominent sources of physician dissatisfaction.

- **Cumbersome:** Most physicians who interact with EHRs directly (without scribes or other assistants) describe cumbersome, time consuming data entry. For many physicians voice recognition systems were not accurate enough

EHRs were designed to support transaction processing and billing and do not adequately provide cognitive support for health care providers and for patients and for family caregivers.

to improve on typing. Physicians who use template-based notes or scribes were less likely to express concern.

- **Interfering:** Many physicians describe the EHR system as interfering with face-to-face patient care. There is a difficult trade off: divide attention between the patient and the keyboard or defer data entry until after leaving the patient and lengthening overall work hours. I always complain to my patients that “I should be poking my patient instead of a keyboard.”
- **Lower Productivity:** Most office based physicians find themselves at lower productivity levels than before the implementation of their EHR. Physicians express frustration that information cannot be exchanged between EHRs. Even when practices invest in EHRs, fax is a common mode of information exchange between care settings. Physicians wonder why interoperability is not a regulatory requirement.
- **Information Overload:** Some EHRs have automatic email alerts to physicians. This has created a sense of information overload, particularly in primary care offices. With or without an alert, the increasing number of messages reaching physicians has expanded beyond the number that we often feel we can manage diligently. If a physician is gone, even for a short while, the volume of messaging to address upon return is astounding.
- **Meaningful Use:** There is a mismatch between meaningful use criteria and what physicians consider to be the most important elements in patient care. Patients who do not provide primary care report that meaningful use criteria seem to be most appropriate for primary care, however primary care physicians report that the documentation burden of

satisfying meaningful use criteria detracts from patient care.

- **Cost:** The investment in EHR systems has exposed practices to considerable financial risk. In particular, the cost of switching EHRs—which is often necessary due to factors out of a practice’s control, is of high concern; and physicians in management positions express concerns about the ongoing costs of maintaining EHR.
- **Low-skill work:** EHR requires physicians to perform lower-skilled work. We talk about people working ‘at the top of their license’ and I am doing data entry and transcription and billing. The derogatory term is ‘scutwork.’
- **Low-quality documentation:** Template-based notes degrade the quality of clinical documentation. It is said that template notes complicate the task of retrieving useful clinical information. In some cases, physicians report that template-based notes introduce enough false information to cast doubt on the medical record more broadly.

Federal agencies are devoting increased attention to this matter. According to the National Institute of Standards and Technology: “usability represents an important yet often overlooked factor impacting the adoption and meaningful use of electronic health record systems. Without usable systems, doctors, medical technicians, nurses, administrative staff, consumers, and other users cannot gain the potential benefits of features and functions of EHR systems.”

The AMA believes that it is imperative to step back and reframe the discussion around the desired future capabilities of the EHR, emphasizing clinical care improvements as the primary focus. We must develop EHRs not as applications that do all things for all people but as a more nimble supportive application that

facilitates the data capture and displays data tailored to the end-user.

AMA recommends eight EHR usability priorities to be addressed and recognizes that many of the recommendations can only be implemented in the long term due to vendor product development cycles, the use of current legacy systems and existing contracts, regulations, and institutional policies.

ENHANCE PHYSICIANS’ ABILITIES TO PROVIDE HIGH QUALITY CARE

Effective communication and engagement between patients and physicians should be of central importance in EHR design. EHRs should fit seamlessly into the practice and not distract physicians from patients. EHR programs should be designed and developed to meet the cognitive work flow needs of physicians.

SUPPORT TEAM BASED CARE

EHR design and configuration must facilitate clinical staff to perform work as necessary and to the extent their license and privileges allow and allow physicians to dynamically allocate and delegate work.

Institutional policies and federal requirements regarding who may enter or perform tasks in the EHR need to support physician-led team based care.

PROMOTE CARE COORDINATION

EHRs should have enhanced ability to automatically track referrals and consultations as well as ensure that the referring physician is easily able to follow the patient’s progress/activity through the continuum of care. The same approach can be used to track orders.

Usable interoperability between EHRs and other forms of health technology is an essential requirement to facilitate the flow of relevant information across care transitions.

OFFER PRODUCT MODULARITY AND CONFIGURABILITY

EHR systems need to offer flexibility so that physicians can configure their health IT environment to best suit their workflow and patient population.

REDUCE COGNITIVE WORKLOAD

EHRs should support medical decision-making by providing concise, context sensitive, and real time data uncluttered by extraneous information.

Preferences can include how reminders and alerts are presented and whether or not reminders and alerts require action before the physician can proceed to the patient's medical record.

We must develop EHRs not as applications that do all things for all people but as a more nimble supportive application that facilitates the data capture and displays data tailored to the end-user.

EHRs need to offer more flexibility in workflow design, data entry, and data presentation to accommodate the physician's skills

PROMOTE DATA LIQUIDITY

EHRs should facilitate connected health care-interoperability across different venues. This means not only being able to export data but also to properly incorporate data from other systems.

FACILITATE DIGITAL AND MOBILE PATIENT ENGAGEMENT

Patients themselves can be useful sources of their own medical information when well-designed tools and processes are in place. Interoperability between a patient's mobile technology, tele-health technologies, and EHRs will be an asset.

EXPEDITE USER INPUT INTO PRODUCT DESIGN AND POST-IMPLEMENTATION FEEDBACK

An essential step to user-centered design is incorporating end-user

feedback into the design and improvement of a product.


The AMA is committed to improving EHR usability for physicians. The AMA plans to use these eight EHR usability priorities to:

- Work with vendors to develop usable EHRs and evaluate their usability
- Advocate federal and state policy makes to develop effective Health IT policy
- Collaborate with institutions and health care systems to develop effective institutional health IT policies
- Partner with researchers to advance health IT research
- Educate physicians about these priorities so that we can lead in the development and use of future EHRs that can improve patient care

'So, AMA, what have you done for me lately?'

This is one of the things AMA is doing for us. We need to each continue to give our concerns about our own EHR to our administrators and IT team so that feedback from the end users (you and me) drives the evolution of our EHRs.

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

Well, back to having a patient talk into my ear while I peck at the keyboard. 

SAVE THE DATE!



NDMA 128th Annual Meeting

September 25, 2015

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NDMA in Action

Est. 1887 NORTH DAKOTA MEDICAL ASSOCIATION

The Session of Scope, Behavioral Health, Cutting Back, and Overall Success

As the dust settles after the 2015 legislative session, it is time to reflect on all the ups and downs during the 2015 session. Although, there are a few particles of dust remaining with a special session looming on the horizon.

IT WAS THE SESSION OF SCOPE

Scope battles are particularly challenging because the North Dakota legislative body has an unnerving dislike of any conflict between professions. Time and time again we are accused of creating a turf war, when in fact we did not introduce the legislation and our only objection is in the name of patient safety.

NDMA was supportive of several groups this session seeking to

expand or establish scopes of practice. NDMA did not object to the licensure of acupuncturists and testified in support of the licensure of the medical technologists. NDMA was very supportive, and NDMA members initiated the expansion of, nurse practitioner's scope of practice in commitment hearings and encouraged the physician assistants to seek inclusion. NDMA realizes that the way to provide greater access to care is to utilize mid-levels to the greatest extent.

However, in the case of the naturopaths and the medical psychologists, that was not what was being proposed. Neither naturopaths nor psychologists are trained in any way similar to nurse practitioners, physician assistants, or physicians in matters of prescribing.



Courtney M. Koebele, JD

Psychologists simply receive no biomedical training, at all. This bill would have allowed them to prescribe psychotropic medications after taking a few courses, some of them online. Without a doubt, North Dakota needs more behavioral health providers. With the collaborative models of care, and the telemedicine alternatives, we are getting behavioral health providers out to all areas of the state. NDMA and the North Dakota Psychiatric Society partnered with the American Psychiatric Society and POPP (Psychologists Opposed to



Prescription Privileges) to oppose the legislation with an extensive grass-roots campaign, and the bill was defeated.

Naturopaths are trained to provide health care under naturopathic theories and not to prescribe standard drugs. They study homeopathy, botanical medicine formulation, naturopathic theory, and practice. They have four additional years of school beyond their bachelor's degree and no residency requirements. Naturopaths are only licensed in 17 states. NDMA did not object to their initial licensure in 2011. But in 2015, they introduced this proposal to expand their scope to include prescription, office procedures, and midwifery; areas in which they are not properly trained. In North Dakota, they are not even licensed by a medical board – they are in the integrative health board, which governs naturopaths, music therapists, and now acupuncturists. The ethics involved in prescribing and midwifery are serious issues that the integrative health board is not prepared to address. Many of our members contacted their legislators and testified before the human services committees to express their concerns.

Unfortunately, the naturopath's message that they were trained properly carried weight with legislators. It is difficult to explain that the training received by the two professions – medicine and naturopathy – may have similar names – but the quality, let alone the quantity, is not the same. Some legislators understood the message – and others did not want to hear it. Fortunately, our concerns were heard by the majority, and the bill was ultimately defeated. It was not without a lot of hard work and grassroots level contacts by our members. Scope expansion is an issue that is not going away, and we need to determine the best way to approach scope issues by NDMA in the future.

IT WAS THE SESSION OF BEHAVIORAL HEALTH

At the outset, there were over 18 filed bills that directly affected behavioral health services. Many more bills and budgets had components which

addressed behavioral health issues. Of those 18 bills, the ones that were policy-only and contained no additional funding requirements passed. Examples of those bills include the Good Samaritan bill, the expanded commitment law bill, and the naloxone immunity bill. The bills that contained any sort of funding requirements were pared down to the bare minimum or defeated entirely. Examples of those types of bills were expanded brain injury programming, loans and grants for behavioral health professionals, and enhanced behavioral health services in general. The 18 bills requested \$15.5 million in appropriations from the state – the funding ultimately granted was approximately \$1.2 million. On a positive note, awareness for behavioral health was raised significantly for the legislative body and some interim studies were approved. This is a state-wide concern that needs to be addressed – and there will be more to come in resolving these needs for our state.

IT WAS THE SESSION OF CUTTING BACK

Because of the drastic decrease in the cost of oil, it was also the session of “cutting back.” Coming into the session, we thought we had an abundance of funds. We were wrong. But so was the Governor's budget. The Governor drafted his budget based on tax revenue projections that were drastically decreased while the 2015 legislature was in session. Every single budget was combed over and cut. Many new proposals were declined. In the end, our section of the human services budget, Medicaid reimbursement for providers, was increased 3%. Medicaid reimbursement was originally 4% in the governor's budget, it was reduced to 2%, and then finally settled on 3% in conference committee. We consider this a success. In another victory, the UND School of Medicine and Health Sciences received the full funding requested for the Healthcare Workforce Initiative. The new medical school building is on time and on budget. NDMA is a proud supporter of the medical school and looks forward to partnering with the

school to help increase the provider workforce in North Dakota.

There were some disappointments. The NDMA Assault against Health Care Providers bill was defeated, despite overwhelming support from all health care providers and systems across the state. Some policy makers did not believe such a high felony penalty should be imposed on certain types of assault. However, we are not giving up on this cause. Many good ideas take more than one session to become reality. NDMA plans on educating the legislature on the nature of the assaults that occur in the workplace for health care providers and finding a compromise. Another loss was when the proposed raise in tobacco tax was defeated. NDMA partnered with the North Dakota Cancer Coalition, Tobacco Free North Dakota, and others to seek an increase in the tobacco tax to help reduce youth and adult smoking. The makeup of our legislature is such that a raise in any sort of tax would be extremely unlikely to pass at this point.

All in all, a good session for NDMA. NDMA was involved in some heated battles, and we stayed out of the fray on some. We look forward to the interim with many studies regarding health care issues and many opportunities for NDMA to influence public policy.

I would like to thank the UND Center for Family Medicine–Bismarck for providing a doctor of the day every Wednesday of the session and the numerous others who graciously volunteered their time. The legislative body and their staff enormously appreciate NDMA's contribution through the doctor of the day program. I cannot emphasize enough how this program supports our advocacy efforts. Many kudos to Dr. James Brousseau and Altru Health System for providing health screenings to over 100 legislators and legislative council staff members. A final thanks to NDMA communications director and co-lobbyist Katie Fitzsimmons who helped me represent NDMA in the good times and the bad and kept me sane during the floor votes. §

Growing Season

News from the Dean of the UND SMHS

It has been a busy six months since my last report to you here in the *ND Physician* that was published in December 2014. A major focus of the School's external activities centered on the 64th Legislative Assembly that recently adjourned after a 78-day session. North Dakota's Legislature showed continued strong support of the School and our focus on healthcare workforce generation as well as biomedical innovation and research that benefit the people of North Dakota. Funding was appropriated to complete the construction of the new building, fully fund the Healthcare Workforce Initiative (HWI), the RuralMed Scholarship Program, and all of our base funding needs. In addition, the Legislature provided new funding to the School to expand the outstanding forensic pathology effort headed by Dr. May Ann Sens. There also were important new financial resources provided to the Department of Human Services to support our expanded Psychiatry Residency Program that has telemedicine as its focus. We are extremely grateful to the members of the Legislature and Governor Jack Dalrymple for their terrific support of the School and our efforts on multiple fronts to address a variety of community healthcare needs. Here is a brief update regarding a number of other programs and items that may be of interest to members of the North Dakota Medical Association:

- Graduation – The SMHS now has 55 new medical and 208 new health sciences alumni following medical school graduation on May 9 and UND graduation on May 16. Our newest physician graduates have matched at outstanding residencies both in North Dakota and elsewhere, and the health sciences graduates are headed to great practice opportunities as well. As we did last year, we led the nation in the percentage of our graduates who

are going into family medicine (based on a rolling three-year average determined by the American Academy of Family Physicians); although this year, the most popular residency choice was pediatrics with family medicine just behind.

- Student Debt and Philanthropy – Over the past several years, we've been able to significantly lower medical student debt at graduation through increased philanthropy and our RuralMed Program. Over the past five years, thanks to generous donors, the School has been able to increase its scholarship awards by about 50 percent. But with continued focus on the importance of philanthropy to mitigate student debt, we hope to do even better in the future.
- Construction – The new building continues to be on schedule – and on budget. All of the concrete for the floors and roof has been poured, many of the internal walls are up, and a good deal of the HVAC (heating, ventilation, air conditioning) ductwork is in place. On May 19, several beams that had been signed by hundreds of well-wishers were hoisted into place as part of the building's Topping Off ceremony. We are on schedule to open the doors of the new home for the SMHS in the summer of 2016. But some SMHS units will remain where they currently are located. One long-awaited renovation finally is underway, as lab space on the first floor of the current building is being renovated to accommodate members of the epigenetics group (which investigates how cells change because of factors other than an alteration in genetic code). The epigenetics research is supported



Joshua Wynne, MD, MBA, MPH

by a \$10.5 million five-year grant from the National Institutes of Health.

- LCME Update – The Liaison Committee on Medical Education accredits medical school curricula, and as you know, we were cited for some deficiencies when a survey team visited us in March 2014. We have been working hard on an Action Plan to address all of the citations, and we are scheduled for a limited revisit on Oct. 18–21 of this year. Preparations for the visit are in high gear, and are being coordinated by Associate Dean for Educational Administration and Faculty Affairs Dr. Ken Ruit, under the supervision of Senior Associate Dean for Education Dr. Gwen Halaas. Further updates will be provided as we get even closer to the visit, but please mark your calendar if you are or may become involved in the reaccreditation process.

So there is much positive movement and growth at the School. But one thing that remains constant is the dedication and support that the School gets from the many voluntary community-based faculty members in the North Dakota Medical Association who give so generously of their time to teach our medical and health sciences students. We couldn't do it without you! And we – and the students – are enormously grateful for your gift of time, knowledge, and experience. Thank you! 🍷



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- Test Your Systems and Processes—Test within your practice and with your vendors and payers

Now is the time to get ready.

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Summary of the 2015 Annual AMA Meeting

A Report from our AMA Delegate

Alternate Delegate Shari Orser, MD, President Steven Strinden, MD, and I attended the Annual Meeting in Chicago, June 4 – 10. In an address during Saturday’s opening session of the 2015 AMA Annual Meeting, outgoing AMA President Robert M. Wah, MD, congratulated physicians on undertaking numerous challenges that, once solved, will strengthen the physician-patient relationship and make the practice of medicine better. Dr. Wah noted that the most important victory for physicians over the past year was undoubtedly the elimination of Medicare’s sustainable growth rate (SGR) formula, a perennial threat of steep payment cuts and instability. “Working together, we finally ended an era of uncertainty for Medicare patients and their physicians and opened new avenues to provide better care at a lower cost,” he said. “It wasn’t a ‘doc fix’ It was Medicare that needed fixing—not doctors.”

Policies addressed at the meeting included:

Better Coverage for Behavioral Health

The new policy called for increased access and coverage of integrated medical and behavioral health care services. The new policy directs the AMA to urge Medicaid and private health insurers to pay for physical and behavioral health care services provided on the same day. The AMA also will encourage state Medicaid programs to amend plans as needed to include payment for behavioral health care services in school settings in order to identify and treat behavioral health conditions as early as possible. Finally, the AMA will promote developing sustainable payment models to assist programs that currently rely on short-term funding to continue integrating behavioral health care services into primary care settings. More than 40 million adults have a mental illness and 6 million children suffer from an emotional, behavioral, or developmental issue. Data shows fewer than one-half of these people receive treatment.

Maintenance of Certification

Physicians took on the maintenance of certification (MOC) process, calling for more transparency and education surrounding the process. One new policy, based on an AMA Council on Medical Education report, asks the American Board of Medical Specialties (ABMS) to develop “fiduciary standards” for its member boards.

The policy asks the ABMS to urge full transparency related to the costs of preparing, administering, scoring, and reporting MOC exams. It also seeks



Robert Beattie, MD

to ensure MOC “doesn’t lead to unintentional economic hardships.”

Other new policies direct the AMA to work with the ABMS toward the following changes:

- Any assessment should be used to guide physicians’ self-directed CME study
- Specific content-based feedback after any assessment should be provided to physicians in a timely manner
- Multiple options should be available for how an assessment could be structured to accommodate different learning styles
- Physicians need to know what their specific MOC requirements are and the timing around when they must complete those requirements. The policy directs the AMA to ask the ABMS and its member boards to develop a system to alert physicians to the due dates of the multi-stage requirements of MOC
- Part III of the MOC exam, typically known as the high-stakes exam, should be streamlined and improved. The policy also calls for exploring alternative formats

Grace Period for ICD-10 Penalties

With less than four months to go before the deadline for implementing the ICD-10 code set, physicians agreed to seek a two-year grace period for physicians to avoid financial penalties to facilitate a smoother transition that would allow physicians to continue providing quality care to their patients without undue disruption.

Physicians at the 2015 AMA Annual Meeting passed policy calling on the Centers for Medicare & Medicaid Services (CMS) to wave penalties for errors, mistakes, or malfunctions in the system for two years directly following implementation. The policy stipulates that CMS should not withhold physician

payments based on coding mistakes, “providing for a true transition, where physicians and their offices can work with ICD-10.”

The most important victory for physicians over the past year was undoubtedly the elimination of Medicare’s sustainable growth rate (SGR) formula, a perennial threat of steep payment cuts and instability.

Physicians at the AMA meeting underscored their commitment to reverse the overdose epidemic. Among the policies adopted to this end were ones that called for increased reliance on prescribing data, more robust education, and adequate coverage for addiction treatment.

Related policy pushes the AMA to advocate for physician voices to be part of the group that manages the International Classification of Diseases (ICD). Currently, the four cooperating parties that manage ICD code sets are the Centers for Disease Control National Centers for Health Statistics, CMS, the American Hospital Association, and the American Health Information Management Association. A physician group is necessary in these conversations because none of the current groups “represent providers who have licensed authority to define, diagnose, describe, and document patient conditions and treatments.”

The new policy also directs the AMA to seek data on how ICD-10 implementation has affected patients and changed physician practice patterns, such as physician retirement or moving to all-cash practices.

Solutions for the Drug Epidemic

Physicians at the AMA meeting underscored their commitment to reverse the overdose epidemic. Among the policies adopted to this end were ones that called for increased reliance on prescribing data, more robust education, and adequate coverage for addiction treatment. Doctors directed the AMA to pursue the following solutions:

Encourage physicians to use state-based prescription drug monitoring programs (PDMP).

- Urge states to implement modernized PDMPs that seamlessly integrate into physicians’ work flows and provide clinically relevant, reliable information at the point of care. The policy also calls for sharing access to PDMP data across state lines under appropriate safeguards for protected health information and using uniform data standards to facilitate this information sharing
- Work with the National Alliance for Model State Drug Laws and other national organizations to enhance physicians’ ability to review their own prescribing information in PDMPs
- Intensify collaborations with public and private stakeholders to reduce harm from inappropriate use of opioids and other controlled substances, increase awareness that substance use disorders are chronic diseases and must be treated accordingly, and reduce the stigma associated with patients who suffer from persistent pain or substance use disorders
- Advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that are physician-led and support health insurance coverage that gives patients with a legitimate need for chronic pain management access to the full range of evidence-based modalities

Public Health Policies

Approved were a variety of public health policies that could influence how patients stay healthy in the years to come.

1. Ensuring energy drinks have child-resistant packaging to prevent hospitalizations and deaths
2. Requiring written consent from a physician or member of a physician-led care team for youth athletes suspected of having sustained a concussion to be allowed to return to a sport
3. Securing labels on sunglasses that state the percentage of UVA and UVB radiation protection of the product to ensure consumers are aware of the extent to which their eyes would be protected
4. Requiring hand-held electronic devices that use headphones and earbuds to include warning labels about the dangers of headphones use in public because they impede hearing
5. Developing a list of best practices guiding the development of mobile medical applications to help ensure their efficiency and trustworthiness. The policy follows the release of a report on the subject by the AMA Council on Science and Public Health, adopted at the 2014 AMA Annual Meeting
6. Setting the minimum age for purchasing electronic cigarettes to 21 and packaging liquid nicotine in child-resistant containers
7. Addressing the prescription overdose epidemic
8. Increasing what patients can contribute to flexible spending accounts by a reasonable amount to help overcome financial barriers to receiving the care they need
9. Banning the use of artificial trans fat in food

GME Funding and Doctor Shortage

Policy was adopted calling for the AMA to advocate for continued and expanded Graduate Medical Education funding from federal, state, local, and private sources.

Specifically, the AMA will push for federal funding for the National Health Care Workforce Commission, which is charged with identifying barriers limiting health care workforce production and encouraging innovations that can address the current and future personnel requirements of the health care system. The policy asks the commission to provide the nation with data and policy that supports the value of GME.

Related policy on GME funding also adopted at the meeting includes:

1. Collaborating with the Association of American Medical Colleges, the National Resident Matching Program, the American Osteopathic Association, and other

stakeholders to study the common reasons medical students fail to match to residency slots

2. Directing the AMA to study and report back on potential pathways to reengage in medicine for those who do not match
3. Urging Congress to reauthorize the Teaching Health Center Graduate Medical Education Program to its full and ongoing funding needs. The program currently supports 60 training centers with 550 primary care physicians and dentists in underserved areas

The new policies are timely, considering the recent record-breaking number of unmatched students who have graduated from medical school without securing a place to complete their training.

Immunization Policy

Policies adopted at the meeting call for immunization of the population—absent a medical reason for not being vaccinated—because disease exposure, importation, infections, and outbreaks can occur without warning in communities, particularly those that do not have high rates of immunization. That begins with health care professionals involved in direct patient care, who have an obligation to accept vaccinations to prevent the spread of infectious disease and ensure the availability of the medical workforce.


Other policies include:

- Supporting the development and evaluation of educational efforts, based on scientific evidence and in collaboration with health care providers, that support parents who want to help educate and encourage their peers who are reluctant to vaccinate their children
- Disseminating materials about the effectiveness of vaccines to states
- Encouraging states to eliminate philosophical and religious exemptions from state immunization requirements
- Recommending that states have an established decision mechanism that involves qualified public health physicians to determine which vaccines will be mandatory for admission to school and other identified public venues

Research on Violence Against Physicians

Physicians at the 2015 AMA Annual Meeting passed policy to support a new study on methods that will prevent violence against physicians and other health care professionals while in the workplace. This policy arrives less than six months after a Boston cardiac surgeon was fatally shot by a man suspected to have a grudge, underscoring the need for more stringent policies that protect physicians.

Health care workers experience the most nonfatal workplace violence compared to other professions, with attacks at hospital and social service settings accounting for almost 70 percent of nonfatal workplace assaults, according to data from the Bureau of Labor Statistics.

There also have been more than 150 shootings in health care facilities in the past decade, which has prompted some states to adopt legislation banning guns in hospital settings, according to a study in the *Annals of Emergency Medicine*. 

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5 Ways Health Care Will Look Different in the Post-SGR Era

An AMA Viewpoint

Our nation stepped into a new era for health care when it adopted legislation to eliminate Medicare's sustainable growth rate (SGR) formula.

Medicare had been locked in persistent instability thanks to this failed budgetary gimmick created in 1997. Yes, you read it correctly: 1997. That's back when we were using dial-up connections, the general public was just becoming aware of the possible Y2K catastrophe, and Google had yet to appear on the market.

For more than a decade, the unified voice of medicine tirelessly called on lawmakers to release Medicare into the 21st century. And now it has happened.

With SGR behind us, we now can build a forward-looking health care system that puts patients first—a system in which we can provide cost-effective care with top-notch health outcomes in a sustainable practice environment.

Here are five ways our health care system will begin to look different:

1. Medicare and TRICARE patients will no longer face constant uncertainty over whether they might lose their access to care

The perennial threat of devastating payment cuts under SGR made it difficult for many physicians to know whether they would be able to keep their doors open for treating these patients.

2. Physicians' practices will be more sustainable

Under the new law, many of the competing quality-reporting programs in Medicare will be consolidated and better aligned. The risk of penalties also has

been substantially reduced, and physicians now have potential for earning significant bonuses.

3. The path will be cleared for new models of care

The new law not only removes the financial instability caused by the SGR formula but also provides monetary and technical support for those who choose to adopt new models of care suited to the 21st-century needs of physicians and their patients.

One of our primary goals at the AMA is to further lift physicians' regulatory burdens and provide practical resources to advance professional satisfaction and practice sustainability. Now that the SGR is out of the way, we can ramp up these efforts.

For more than a decade, the unified voice of medicine tirelessly called on lawmakers to release Medicare into the 21st century. And now it has happened.

4. Health outcomes will be improved in the clinic setting and the community

Chronic diseases have become the primary sources of poor health and death today. Treating these conditions requires new approaches, and the new law permanently requires Medicare to pay for care management of these patients.



Robert M. Wah, MD
Immediate Past-President

We have an initiative underway that is developing ways physician practices can partner with their patients and the community to prevent two of the most common chronic conditions—heart disease and type 2 diabetes—before they start. We're also advocating for Medicare and other insurance plans to cover evidence-based prevention programs.

5. Physicians in training will be taught how to practice in the new health care environment

Even as the health care system undergoes dramatic change, an AMA consortium of medical schools is exploring how to prepare the next generation of physicians for practicing in the new environment. Students will learn how to succeed in new models of care, provide high-quality but cost-effective care, and team up with other health care professionals and the community so their patients can lead the healthiest lives possible.

Just as we partnered in the past to end an unsuccessful system that hindered our practices and threatened our patients, let's step into the future together. Let's shape this new era of health care into one in which our profession and our patients thrive.

This originally appeared in the AMA Wire on April 21, 2015.

<http://www.ama-assn.org/ama/ama-wire/post/5-ways-health-care-will-look-different-post-sgr-era>

2015 Legislative Summary: NDMA Advocacy at Work

The 64th North Dakota Legislative Assembly met for 78 days, adjourning on Wednesday, April 29. During the four months of the session, NDMA worked alongside other groups and organizations to champion the legislative agenda that NDMA members adopted in the fall of 2014.

NDMA supported 11 broad policy concepts this session: efforts to enhance North Dakota's workforce climate for physicians and other health professionals; additional state medical liability reforms and protect existing reforms; the independent medical judgment of physicians in medical practice; Medicaid payment increases for physicians and hospitals; Medicaid program and management reforms; public health reforms; ways to enhance patient decision making; funding increases in the UND SMHS budget; efforts to encourage strategies and plans for health information technology; expanded coverage for the uninsured and underinsured people, including children; and the physician scope of practice and oppose inappropriate challenges to that scope. These concepts, along with ongoing conversations with our board, guided our advocacy efforts.

Returning to the chambers were two of NDMA's members, both re-elected in the Fall of 2014: Representative Dr. Rick Becker (R-7) and Senator Dr. Ralph Kilzer (R-47). Both legislators supported policy that ensured patient safety. In addition to the legislative action, NDMA was proud to be involved with other happenings on the hill. On January 20 and 21, James Brosseau, MD, with assistance from Altru Health System staff members, coordinated a Personal Wellness Assessment program in The Great Hall



By Katie Fitzsimmons,
NDMA Communications Director

for legislators and legislative staff. The program was well-received during the 2009, 2011, and 2013 sessions, and this year was no different. We greatly appreciated Dr. Brosseau's efforts, as did the 100+ individuals who took advantage of the assessment!

Again this session, NDMA teamed up with the North Dakota Hospital Association and the North Dakota Emergency Medical Services Association to sponsor Physician and Hospital Day on Wednesday, February 23, 2015. This provided a face-to-face opportunity for physicians to meet with legislators to discuss important issues, attend various bill hearings throughout the day, and get to know their lawmakers over lunch. We look forward to co-hosting the third Physician and Hospital Day in 2017.

And finally, the Doctor of the Day program was a success once again. All of our volunteers had varying experiences; some were slammed for their entire shift, others were able to take in some conference hearings or floor sessions between patients. Nonetheless, it was a service that was appreciated by everyone and overall, it was well-utilized by our legislators. Thank you to all of our volunteers!

Thank you to our 18 Doctor of the Day volunteers, who provided care to the legislators and staff during 30 days of the 78-day long session. Many of these served more than one day, or even as many as five! This service is well-revered and appreciated; thank you for sharing your time, and many thanks to the UND Center for Family Medicine in Bismarck for providing one day of coverage each week!

Paul Bahal, MD
James Brosseau, MD
Sue Dhamija, MD
Deb Geier, MD
Raymond Gruby, MD
Jeff Hostetter, MD
Ted Kleiman, MD
Jill Klemin, MD
Craig Lambrecht, MD
Jau-Shin Lou, MD
Jackie Quisno, MD
Sarah Schatz, MD
Steve Strinden, MD
Guy Tangedahl, MD
Karin Willis, MD
Dennis Wolf, MD
Joshua Wynne, MD
Rodney Zimmerman, MD



All told, NDMA tracked 131 bills. Many of those were left in the category of monitoring, but others did require action, testimony, and extensive lobbying efforts. Some high-profile bills garnered strong attention from the public, especially issues regarding PERS, cancer treatment and diagnosis, and medical marijuana. Here is a rundown of some of the notable bills that we tracked and/or took action upon, categorized for easy reference. You can also access this list on our interactive [Bill Tracker on our website](#). This tracker will be available and accessible for several more months and you can always request additional information from our office.

LEGISLATIVE ISSUES

Before the start of the session, NDMA identified four main areas that would require much attention: Medicaid reimbursement, the medical school budget, behavioral health, and scope of practice issues (if patient safety was at risk). There were starkly different tones in December during the Organizational Session, in January when the Session began, and in mid-March when the Office of Management and Budget (OMB) announced the new budget projections. The drop in oil prices caused the legislative body to tighten its purse strings, which also impacted how we approached bills and legislators. When the Governor crafted his budget in 2014, the price of oil was over \$90 per barrel, but he and OMB used a conservative figure of \$72 per barrel. When the organizational session convened in early December 2014, prices had dropped to roughly \$60 per barrel, and by the time the 64th Assembly began in January, oil was hovering around \$45 per barrel. Because of this trend, it was made known that if something was not outlined in the Governor's budget, it would not receive funding, and if it was in the Governor's budget, it could remain, but funding would be reduced.

MEDICAID

Human Services/Medicaid budget (SB 2012) passed both chambers. The Governor's budget called for the 4% inflator for each year of the biennium, but the Senate cut that to 3%. Once it reached the House, the House further cut the inflator to 2%. After extensive discussion at the conference committee level, the bodies restored the inflator to 3%. Considering the way this budget, along with all other department budgets, was approached, we are satisfied with the 3% inflator. The budget for the Department of Human Services is extensive; it totals \$3,515,609,581 for the biennium. However, keep in mind that even with that large price tag, many of their services and programs were not granted their full funding requests.

UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE AND HEALTH SCIENCES

[HB 1003](#) detailed the budget for the North Dakota Higher Education System. Within it, UND SMHS outlined several needs, which were met. The school will continue to receive

Before the start of the session, NDMA identified four main areas that would require much attention: Medicaid reimbursement, the medical school budget, behavioral health, and scope of practice issues (if patient safety was at risk).

the required funding to continue the Healthcare Workforce Initiative program (HWI), required baseline funding, funding for new residency positions, and support for the RuralMed program. Please refer to Dean Joshua Wynne's column for more information.

BEHAVIORAL HEALTH

With the decrease in oil prices, all bills across the spectrum with a fiscal note were hit hard. And, with any legislative process, bills were amended and combined along the way. As far as behavioral health bills, those without a fiscal note fared better than those with one. Overall, these bills and the Schulte Report brought a new awareness to the chambers in regards to behavioral health needs across the state, but there is a lot of progress yet to be accomplished. At the end of this article, you can review the interim studies that will be taking place. In total, there were 20 bills that had some tie back to behavioral health in one way or another; here are a few that we tracked.

[HB 1048](#) related to the uniform licensing for the board of addiction counseling examiners, board of counselor examiners, board of social work examiners, state board of psychologists examiners, state board of medical examiners (renamed to Board of Medicine as of July 2015), and marriage and family therapy licensure board. These groups shall develop a plan for the administration and implementation of licensing and reciprocity standards for licensees. Duane Houdek from the Board of Medicine will facilitate these discussions.

Licensed Marriage and Family Therapists (LMFTs) popped up in a few bills as a means to expand services. [SB 2046](#) allows LMFTs to enroll as Medicaid providers (but is subject to limitations). [SB 2047](#) originally allowed LMFTs to be included in the definition of a qualified mental health professional in the context of children's residential treatment facilities, but after amendments and revisions, that language was removed from the bill. As a result, the Department of Human Services will now adopt rules defining which professional groups may provide treatment plans to children.

This issue could be considered a scope issue or a behavioral health issue. Prior to the session, some psychiatrists approached us about supporting a bill that would allow qualified mid-levels to testify at commitment hearings. In many cases, a Nurse Practitioner or Physician Assistant, with special certification, would be qualified to provide



testimony for these cases. Also, the judicial process can be time consuming and require a physician to cancel patients at the last minute in order to accommodate a delayed trial. HB 1040 would allow for qualified professionals, other than a psychiatrist, to provide testimony in a commitment hearing. NDMA supported this bill from the beginning, along with the nurses, the psychiatrists, and physician assistants.

[SB 2048](#) received bits and pieces of a few different bills and it transformed from its original form and funding amount. At the beginning, this bill requested \$6,225,000 and the final approved amount was \$900,000. Here are some of the notable things this legislation does:

1. Requires school boards ensure a candidate for teacher licensure demonstrates competencies in youth mental health and school districts provide a minimum of eight hours of training on youth mental health (to staff) once every two years
2. Provide \$150,000 to DHS for one full time employee for the purpose of facilitating the behavioral health planning protocols for discharge or release of individuals with behavioral health issues
3. Provides \$750,000 to DHS to establish and administer a voucher system to address underserved areas and gaps in the state's substance abuse treatment system and to assist in the payment of addiction treatment services provided by private licensed substance abuse treatment programs
4. Directs studies of mental health resources, behavioral health needs, and access to services

[SB 2049](#) was turned into a study by DHS that will examine all statutory references to mental health professionals.

MEDICAL PRACTICE

Scope Of Practice

One of the biggest bills of this session for us was SB 2194 which would have allowed Naturopathic Doctors (NDs) to prescribe, perform in-office procedures, and conduct midwifery (with an additional certification). NDMA Executive Director Courtney Koebele discussed this bill in more depth in her column. In short, we found, through our research, that though NDs receive four years of education beyond an undergraduate degree, the training they receive is nowhere near on par with what physicians receive. The naturopaths argued that their training is similar to that of a nurse practitioner or physician assistant, and still, the hours and clinical experience, in our opinion, based off our research, did not compare and did not qualify NDs to prescribe or expand their scope in any way. We objected to the passage of this bill completely in the name of patient safety.

Initially, the bill was defeated in the Senate in February, but one senator reconsidered his vote the following day, and the vote flipped from a defeat of 22-25 to a passage of 25-22. On Thursday, April 2, it reached the House floor with a Do Pass recommendation (11-2) from the House Human Services committee, despite our strong and solid testimony that supported a Do Not Pass recommendation. Ultimately, after strong lobbying, physicians reaching out to their representatives, and favorable (for us) floor discussion, it was defeated by a vote of 35-56. The naturopaths tried again to have this vote reconsidered, but that did not happen. They mobilized a nationwide grassroots effort and hammered the legislators with emails and letters. It is our understanding that they will return in the 2017 session, as they have already discussed that plan publicly. If you would like to see how your senator and representatives votes, click here ([page 1 of the Senate Journal 457](#) and [page 17 of the House Journal 1309](#)).

The other time-consuming and also successful scope battle was the medical psychologists, [HB 1272](#). The bill would have allowed psychologists to prescribe psychotropic medications with a small amount of additional training. Similar action has failed over 181 times in 25 states over the last 20 years. The advocates for this bill argued that medical psychologists could serve those in need of services, especially in the western portion of the state. NDMA partnered with the North Dakota Psychiatric Society (NDPS) and provided solid and comprehensive testimony. Before the bill reached the House floor for a vote, the bill was amended into a mandatory study. Because of the quick transformation of the bill, it was not prudent to oppose it as a study, so it passed the House. Once it reached the Senate, NDMA and NDPS regrouped and continued to oppose the bill, founded on the notion that the study was unnecessary, it would be a waste of funding, and patient safety would be at risk. The bill died on the Senate floor 6-41.

[SB 2236](#) provided for licensure of medical imaging and radiation therapists through the establishment of a board. However, this exempts physicians, dental hygienists, those performing post-mortem imaging, and a few other groups from required licensure. NDMA supported this bill as licensing these professionals will save time and shore up communication within the care team model.

The Athletic Trainers sought to redefine the language contained in the code through [SB 2295](#). NDMA was at the table for this same discussion in 2013, which ended up being dropped, and though we were part of some of the discussions this session, we largely remained removed from it all. Some of our physician members were strong advocates for the proposed changes. Physical and Occupational Therapists were highly involved and by the end of the session, all parties seemed to be reasonably satisfied with the new language. Similarly, in SB 2191, acupuncturists sought licensure this session under the Board of Integrative Health. We did not oppose this movement, and the bill passed.

NDMA was glad to work with orthopaedic surgeons and podiatrists on [SB 2128](#) to arrive at a healthy compromise. The podiatrists were seeking to redefine the definition of podiatric medicine within the code that raised some concerns within the orthopaedic community. Thankfully, we were able to work with the podiatrists prior to the hearing and immediately afterwards to arrive at a compromise. The legislature loves to see the expert professionals work things out to an agreeable conclusion, rather than imposing a solution of their own.

MEDICAL PRACTICE

Non Scope Bills

[SB 2173](#) was really more of a practical housekeeping bill, at least from some vantage points. It deals with collaborative agreements and the new language cleans up the process and protocols that are in place. It now allows Nurse Practitioners to have collaborative agreements with pharmacists, all while still leaving the physician notification and supervision in place. After discussions with the Pharmacy Association, it sounds as if this will streamline care and enhance access for patients while decreasing hassles for providers.

[HB 1149](#), along with a few others we will discuss later, was born from the Reducing Pharmaceutical Narcotics in our Communities through Education and Awareness Taskforce. This piece of legislation allowed for all boards that license individuals that are authorized to prescribe or dispense controlled substances to establish their own administrative rules to require licensees to utilize the Prescription Drug Monitoring Program (PDMP). This is in lieu of requiring mandatory PDMP signup and usage. We have some solid examples of what other states have adopted (such as Ohio), as far as requirements and exceptions. NDMA will be working

closely with the Board of Medical Examiners, Board of Pharmacy, Board of Nursing, and other bodies, to ensure that physicians will have appropriate, reasonable, and responsible guidelines.

And speaking of the Board of Medical Examiners, starting in July 2015, the Board of Medical Examiners will be known as the Board of Medicine, thanks to [HB 1153](#).

[HB 1072](#) tackled the issue of parity for oral chemotherapy drugs. This issue mobilized the cancer community and pharmaceutical companies on the pro side; insurance companies on the defense. Ultimately, the bill passed. The insurance companies, namely Blue Cross, felt that this bill was unnecessary as they already provide parity for oral chemotherapy drugs and that the language in this bill would require the prescription of name brand drugs over generics, thus increasing costs for the entire membership. We shall see how bottom lines are affected.

Another cancer-related issue, and one that received a lot of press, was [HB 1370](#), the dense breast tissue bill. Initially, NDMA was opposed to this bill, as it is an interference into medical practice. Some of our physicians expressed concerns to us that this notification could create more problems and anxiety for patients, rather than relief. Once the bill reached the Senate, NDMA remained neutral on the issue and it passed. Some people see this as a tool for patients and allows for more awareness about breast density, cancer risk, and the efficacy of screenings, while others view this a protocol that will increase anxiety and confusion for patients. However, as screening technology improves across the state, this might become a moot issue. Again, time will tell.

[HB 1279](#), the CARE (Caregiver, Advise, Record, Enable) Act, was a piece brought forth by AARP and it would have required all hospitals, within 24 hours of admission and upon discharge, to identify in the medical records a care taker who would continue with care as designated in the medical record after the patient left the hospital. Hospitals across the state believed that the bill was an unfunded mandate that would have created additional liability beyond their control and thus, they were strongly opposed. Ultimately, the bill did not continue in its original form; it passed as a study.

[SB 2335](#) modified a portion of the code regarding the duty of a physician to report certain injuries.

The code now outlines that when a weapon is involved, whether self-inflicted or not, it must be reported to law enforcement. If the injury is the result of a sexual offense, the reporting physician cannot list the victim's name, address, or identifying information, unless the victim signs a release. These reports are to be filed as quickly as possible in order to avoid penalty.

Community Paramedics came up in [SB 2043](#). As per this bill, the Department of Human Services shall adopt rules governing payments to licensed community paramedics, advanced medical technicians, and emergency medical technicians for health related services provided to recipients of medical assistance.

Medical marijuana hit this session in two different forms- [HB 1430](#) and [HCR 3059](#) (a proposed study). Both started in the House and were handily defeated (26-67 and 32-61, respectively). NDMA testified against HB 1430 along with the Attorney General on the grounds that regulation of the substance cannot be controlled, diversion rates to youth are high, there would be large costs to the state and the Department of Health, and there is no proof to the efficacy of this treatment. This will continue to be an issue in future sessions, as medical marijuana is allowed in 32 states.

SAFETY AND PUBLIC HEALTH INITIATIVES

Tobacco

The Raise it for Health Coalition worked during the interim to drum up support to increase the tobacco tax, which was presented to the legislature in two different bills ([HB 1421](#) and [SB 2322](#)). The tobacco taxation rate has remained unchanged since 1993 and at 44¢ per pack, North Dakota is ranked the 46th, meaning only five other states impose lower tobacco taxes (Alabama, Georgia, Louisiana, Missouri, and Virginia). This current tax rate supplies roughly \$50 million to the general fund each year. Prior to the session, the national average for taxation was \$1.53 per pack, and the average of taxation rates between our bordering states



was \$2.02. North Dakota annual health care costs directly caused by smoking ring in at \$326 million with youth and adult smoking rates holding at 19.4% and 21.2% respectively (which are close to the national averages). During the 2013 House of Delegates, NDMA adopted a resolution to support raising the tobacco tax, as doing such has proven to lower youth smoking and even cause decreased smoking in adults; research estimated 5600 North Dakotans would quit for good if a tax increase occurred.

[HB 1421](#) sought to raise the tax \$1.10 to a total of \$1.54 per pack, but it failed in the House (24-56) after lengthy and emotional testimony. [SB 2322](#) proposed a raise of \$1.56 to a total of \$2.00 per pack. That alone would have generated an additional \$175 million in new revenue over the biennium, which would have been directed into community health trust funds and public health services on the county and city levels. This bill also failed in its originating chamber 17-30.

E-Cigarettes also sparked debate. Three bills were introduced around the topic. Two failed (HBs [1078](#) and [1265](#)), but one received the Governor's signature ([HB 1186](#)). HB 1186 was not a perfect bill, but it moved things in the right direction, according to Tobacco Free North Dakota. Of major significance, HB 1186 termed electronic cigarettes as an "electronic smoking device" and it restricted the sale of e-cigarettes to those that are 18 and older. For a comprehensive look at all the tobacco-related bills, please refer to the guest column by Tobacco Free North Dakota.

Substance Abuse

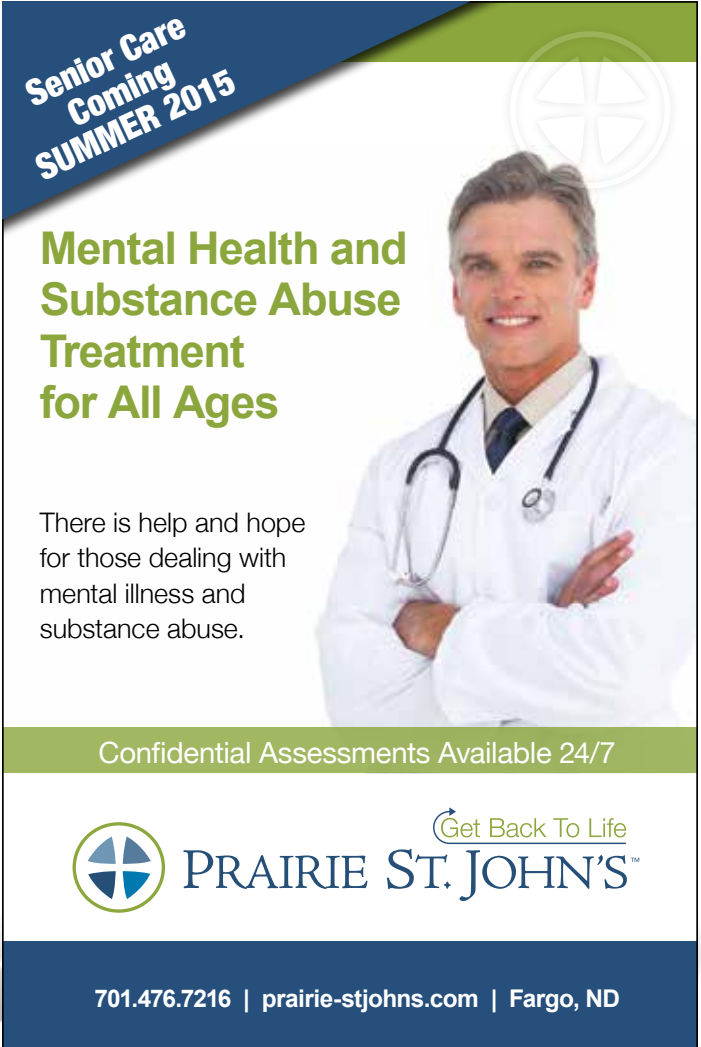
[SB 2070](#) was coined the Good Samaritan bill. Immunity laws are currently in place for incidents involving alcohol, but this bill expands to the involvement of narcotics in the cases of drug overdoses. This bill, along with [SB 2104](#), were fruits of the Reducing Pharmaceutical Narcotics in our Communities through Education and Awareness Taskforce, of which NDMA is a member. SB 2104, the Naloxone bill, allows for wider use of Naloxone rescue kits, which have shown to reduce overdose fatalities. This allows kits to be prescribed to family members of those in recovery, and it might open the door to more first responders carrying and administering Naloxone.

It is not terrifically common for NDMA to track bills that fall outside of the Human Services, Judiciary, Appropriations, or Industry, Business, and Labor Committees, but this session we found ourselves sitting in on Energy and Natural Resources and Transportation for a few bills. In the Energy and Natural Resources committee, a gun bill ([HB 1241](#)) surfaced that held one paragraph of concern for us. The bill primarily dealt with hunting practices, but one section would have forbid a health care professional from asking if a person owned or had access to a firearm. This would be especially troubling when dealing with patients with behavioral health concerns, those in violent domestic situations, and even

those with new circumstances in their life that would require heightened sensitivity to the ramifications of gun ownership (becoming new parents, having someone rent space in your home, etc.). We worked with the Hospital Association and Sanford Health to have this section removed from the bill.

In the Transportation Committee, we worked with law enforcement and the optometrists on a windshield tinting bill ([HB 1427](#)) and a license renewal bill ([HB 1122](#)). HB 1427 would have allowed for drivers to tint their windshields, thus creating more safety concerns for law enforcement and work for health care providers, as this bill would have created a medical exemption to allow for the tinting. HB 1122 would have allowed for online renewal of a driver's license, without requiring an updated vision test. Though this would be a convenience for many people, it would be a large safety concern. Both bills were defeated.

[SB 2284](#) was on a roller coaster for a while, in regards to funding. This bill provided funding for SANE (Sexual Assault Nurse Examiner) nurses. Ultimately, the bill received \$250,000 from oil and gas impact grants that will be in turn used as grants through the domestic violence and rape crisis program for community-based or hospital-based sexual assault examiner programs.




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And finally, our one true disappointment of the session: [SB 2193](#), the Healthcare Provider Assault bill. We introduced this bill and had strong support from the nurses, hospitals, Sanford, and Blue Cross. Currently under statute, if a first responder (police, fire, EMT, or ER worker) is assaulted while performing their job, the perpetrator could be subjected to a felony charge. This includes not just physical contact or force, but could also include the victim being deliberately spat upon, or any other bodily fluid being transmitted onto them, while performing their duties. We saw this as a great fit, as health care providers cannot refuse service to someone, regardless of the danger. If a violent person started to forcibly vomit upon and punch a business owner, that owner could remove the perpetrator from their property and deny that individual services. That is not the case with first responders or health care providers. Of course, if a patient was unable to control themselves, a felony charge would not be applied; this is only for those patients that seek to cause harm to health care providers.

There was no testimony in opposition to the bill, but several of the committee members did not approve of the current statute and thus, they did not want to extend any protections to another class of people. The bill sat in committee for a long

while and then was pushed out and voted upon in committee and then on the floor in less than 24 hours, giving us no time to truly work the bill once we learned of its 0-6 Do Not Pass recommendation. The bill was discussed on the floor for over 25 minutes, but failed with a vote of 15-31 in the Senate.

We will return next session with this bill, after we configure the wording to satisfy the concerns of those that voted against the bill in order to provide more protections to our physicians, nurses, other care team members, and hospital workers.

PERS

The Public Employee Retirement System health plan was a heavily debated and public issue this session. Blue Cross Blue Shield of North Dakota has held the contract for all public employees for years, but this year, the contract went up for bids and Sanford Health won the contract. Some legislators raised concerns about the consistency of coverage, the accessibility of the plans, and if people would be able to continue their care as they always have been able to in the past. Other legislators felt that the Assembly had no business to meddle with this signed contract, as the deal was done and things were progressing forward. Two of the main bills that

Interim Studies Adopted b

Throughout the session, legislative management studies are proposed in order to ascertain needs and current resources in use. On May 27, 2015, the 111 proposed studies were voted upon. 18 were already required and an additional 26 were approved. Of those 44 studies for the interim, 9 caught our interest, including:

[1004 §7](#) (combined with 3004)

Consider studying the feasibility and desirability of the University of North Dakota acquiring the building that houses the University of North Dakota forensic pathology center.

[1018 §25](#)

Consider studying issues related to the state's development of a civilian ground center. The issues include: deployable pilots, sensor operators, and aircraft; a central location for processing first responder data, including high definition, high-spectral, infrared, and thermal imagery, as well as electronic signals through cell phones and Internet service, generated from the deployment of unmanned aircraft and unmanned systems by first responders during federal, state, and local government responses to emergencies, natural disasters, emergency preparedness, and law enforcement activities; training services; data management, data analysis, data interpretation, and information routing approximating a real-time basis; and a repository of data and best practices for first responders at federal, state, and local levels.

[1035 §1](#)

Consider continuing its ongoing study of the needs and challenges of the North Dakota health care delivery system. The study may include monitoring the implementation of the federal Affordable Care Act, examining Medicaid expansion and Medicaid reform, reviewing any impact on rural access to primary health care and emergency services, making recommendations to maintain and enhance rural primary health care and emergency services, and considering the feasibility of developing a state-based plan for a health care model that will comply with federal health care reform in a manner that will provide high-quality access and affordable care for North Dakota citizens. The University of North Dakota School of Medicine and Health Sciences Advisory Council shall make periodic reports to the Legislative Management on the state of the biennial report developed pursuant to North Dakota Century Code Section 15-52-04.

[1279 §1](#)

Consider studying family caregiver supports and services. The study must identify policies, resources, and programs available for family caregivers and encourage additional innovative and creative means to support family caregivers so that they are able to continue to provide in-home support for older adults. The study must include input from stakeholders, including representative of hospitals, social and clinical providers, advocacy organizations, tribal government, state and local agencies and institutions, and caregivers

dealt with this concern ([HB 1300](#) and [HB 1475](#)), were both defeated, but portions of 1475 were inserted into [SB 2022](#), the OMB budget bill. This session ended without a final passage of 2022 because of the PERS controversy. The House and Senate were unable to reach a compromise.

A special appointed committee met on Monday, June 8, to discuss the PERS concerns and SB 2022. After a long meeting, some compromise was reached and the entire assembly will reconvene on Tuesday, June 16, to vote on the final passage of SB 2022.

Also related to PERS: [HB 1038](#), which allows for coverage parity of telemedicine services.

WORKERS COMPENSATION

[HB 1159](#) changed the state law to allow treating physicians to communicate with WSI. This action would not incur liability to the health care provider nor could it provide the basis of disciplinary action against the provider.

Two identical bills, [HB 1317](#) and [SB 2256](#), were filed in an attempt to cover post-traumatic stress disorder (PTSD) in first responders. The Senate handily passed SB 2256, but

both bills were defeated by the House. WSI currently covers some PTSD injuries, as long as a physical injury accompanies the claim. Those types of injuries are termed to be physical/mental claims; this bill would have covered the category of mental/mental claims. WSI received an audit during the last interim period, and this was seen as one area of needed improvement. Despite WSI's support of this bill, and the suggestions set forth in the outside audit, neither bill passed.

The final WSI bill on our radar was the opioid prescribing bill, [SB 2060](#). NDMA worked with WSI prior to the session to work out some concerns, but when the bill hit the Assembly, some of those concerns were not addressed. We provided amendments to the bill, supported by the Board of Medical Examiners, and our deal-breaker concerns were addressed and rectified. Opioids will still be covered; this bill inserts more regulation and safeguards in place.

HOSPITAL LOANS AND OIL IMPACT FUNDING

Several bills were introduced to off-set bad hospital debt, provide grants for infrastructure, and provide better loan repayment options for health care providers. Here are some highlights of what passed:

y Legislative Management

in this state. The study committee may receive testimony on the needs of family caregivers, including designation of caregivers, training, respite services, medical leave policies, and delegation of tasks to non-medical aides. The study must include an inventory of the resources available to family caregivers and may make any recommendations for administrative actions to support family caregivers. The Legislative Management may contract for consulting and coordination of study services.

[1378 §](#)

(Required study) Shall study the proposed and final federal rules issued by the federal Health and Human Services Department relating to the essential health benefits under the federal Affordable Care Act. Specifically, the study must include a review of the rules relating to the state's ability to participate in defining the state-based essential health benefits package for plan years 2017 and beyond, how the state may be authorized to select a benchmark plan for plan years 2017 and beyond, and the deadline relayed to these rules and related decisions.

[2048 §7](#)

Consider studying behavioral health needs. The study must include consideration of behavioral health needs of youth and adults and access, availability, and delivery of services. The study must include input from stakeholders, including representatives of law enforcement, social and clinical service

providers, education, medical providers, mental health advocacy organizations, emergency medical service providers, juvenile court, tribal government, and state and local agencies and institutions. The study must also include the monitoring and reviewing by the 64th Legislative Assembly and other behavioral health-related recommendations presented to the 2013-14 interim Human Services Committee.

[3003](#)

Study state contributions for state employee health insurance premiums, including the feasibility and desirability of establishing a maximum state contribution for state employee health insurance premiums and the effect of losing the state's grandfathered status under the federal Affordable Care Act

[3004](#) (combined with 1004 §7)

Continue to study medicolegal death investigation in the state and how current best practices, including authorization, reporting, training, certification, and use of information technology and toxicology, can improve death investigation systems in the state.

[4004](#)

Continue to study dental services in the state, including the effectiveness of case management services and the state infrastructure necessary to cost effectively use mid-level providers to improve access to services and address dental service provider shortages in underserved areas of the state.

[HB 1014](#) allowed for a revolving loan fund from the Bank of North Dakota for infrastructure grants to hospitals.

[HB 1176](#) provided grants for hospitals and nursing homes: \$10 million for critical access hospitals in oil producing or contiguous counties; \$4 million for nursing homes in oil producing counties; and \$6 million for EMS in oil producing counties.

[HB 1376](#) allows for county and city authorities to donate funds to non-profit health care facilities.

Loan repayment plans are in place, but [HB 1396](#) expanded the funding a small amount. Under it, the health council shall administer student loan repayment services for health care professionals willing to provide services in areas of the state that have a defined need for such services. Loan repayment is not guaranteed; providers must submit an application. Those eligible for repayment include physicians, clinical psychologists, advanced practice nurses, physician assistants, and behavioral health professionals.

The health council shall administer student loan repayment programs, as established by this chapter, for health care professionals willing to provide services in areas of this state that have a defined need for such services.

FINAL THOUGHTS

NDMA is proud of its accomplishments this session and of the strong relationships NDMA has with other lobbying groups, legislators, and constituents. Overall, we view this as a successful session and we stand by the work we accomplished. Things can change quickly at the Capitol, so we are very fortunate that Courtney M. Koebele can dedicate an incredible amount of time to the session, before and after hours. And thank you to all of you that donated your time and expertise to push positive legislation forward. The next session is only a short 18 months away- let the countdown begin!



NDMA Launches New Website

In March, we proudly launched our updated and improved website!

At ndmed.org, you can find all the same information, with some new additions. We are happy to announce that you can register for our Annual Meeting, as well as order an updated Medical Services Directory, through our website. Our biggest new feature is our searchable online Bill Tracker, a tool that is most helpful during legislative sessions. The tracker will be accessible for a while, should you want to look up where NDMA stood on a particular bill and what kind of action we took.

We strongly encourage you to explore our site, utilize the listing of free webinars under Physician Resources, track bills, read our online magazine, and keep up with our news and event listings. Also, follow us on Twitter! Here's where you can find us:

 @NDMedAssn.



May 5, 2015

Dear Member of Congress:

The undersigned organizations – representing Medicare beneficiaries and patients, all sectors of the healthcare industry as well as employers and other purchasers of care – believe strongly that the Medicare program must protect patient access to quality healthcare. The Independent Payment Advisory Board (IPAB), a provision of the Patient Protection and Affordable Care Act (PPACA), not only poses a threat to that access but also, once activated, will shift healthcare costs to consumers in the private sector and infringe upon the decisionmaking responsibilities and prerogatives of the Congress. We request your support to repeal IPAB.

IPAB, as constructed under PPACA, is a board comprised of Presidential appointees who will be charged with making recommendations to cut Medicare expenditures if spending growth reaches an arbitrary level. Once the Secretary of Health and Human Services (HHS) implements an IPAB recommendation, that action is not subject to administrative or judicial review. As constructed, IPAB is granted unprecedented powers – even the ability to change laws previously enacted by Congress – with virtually no oversight.

The potential impact of this board causes deep concern among our organizations and the millions of Americans we represent. IPAB proponents suggest that the board will be an asset in developing needed healthcare delivery reforms. That goal, however, is not realistically achievable. The law requires IPAB to achieve scoreable savings within a one-year time period. Thus, instead of pursuing long-term reforms that may not achieve immediate savings, IPAB is more likely to consider short-term savings in the form of payment cuts for healthcare providers. This was, in fact, the conclusion of the Congressional Budget Office, which stated that IPAB is most likely to focus on payment rates or methodologies for services provided by non-exempt providers.

This would be devastating for patients, affecting access to care and innovative therapies. Already, the number of physicians unable to accept new Medicare patients due to low reimbursement rates has been increasing over the past several years (with almost one of every three primary care physicians, according to the American Medical Association, restricting the number of Medicare patients in their practice). IPAB-generated payment reductions would only increase the access difficulties faced by too many Medicare beneficiaries. Furthermore, payment reductions to Medicare providers will almost certainly result in a shifting of health costs to employers and consumers in the private sector.

Under IPAB's provisions, the responsibility for enacting healthcare system changes of this magnitude would be transferred from the legislative branch to the executive. More specifically, an unelected board without adequate oversight or accountability would be taking actions historically reserved for the public's elected representatives in the U.S. House and Senate. This is an unacceptable decisionmaking process for a program that millions of our nation's seniors and individuals with disabilities rely upon.

Moreover, if IPAB does not act within the law's required timeframe or if IPAB members are not appointed by the President or confirmed by the Senate, the law transfers IPAB's responsibilities solely to the HHS Secretary. This places an enormous degree of power in the hands of one unelected individual.

NDMA Medical Student Awards

2015 - Sophomore Awards



Group Teaching and Professionalism

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



Pictured: Dr. Devendra Pant, Mark Schlotterback, and Dr. Joshua Wynne



Pictured: Dr. Pat Carr, Scott Poswilko, Amy Borys, and Dr. Joshua Wynne

Peer Teaching

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

Integration of Basic Science and Clinical Application

Ability to analyze problems, generate hypotheses, set priorities, test hypotheses and formulate alternative hypotheses, draw appropriate conclusions, and apply the knowledge to patient cases



Pictured: Dr. Kurt Borg, Kyle Rudningen, and Dr. Joshua Wynne

2015 - Senior Awards



Pictured: Dr. Joshua Wynne, Ana Velic, Dr. Steven Strinden, Mckayla Schmitt, and Michael Jordan

Michael A. Jordan, McKayla S. Schmitt, and Ana Velic were the three outstanding graduates of the UND School of Medicine and Health Sciences class of 2015 to receive the prestigious North Dakota Medical Association Award in May 2015, presented by NDMA President, Dr. Steven Strinden. The NDMA award is presented to students who exemplify high scholarship, integrity, leadership, and initiative. Congratulations to all UND SMHS award winners and graduates!

The North Dakota Medical Association Awards

Presented to three outstanding students in the 2015 graduating class

North Dakota District Medical Society Awards

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

First District, Fargo Lucas G. Teske of Fargo



Southwest Campus Dean Julie A. Blehm, MD; Lucas Teske; and Dean Joshua Wynne, MD, MBA, MPH

Third District, Grand Forks Brendan M. Boe of Beulah



Assistant Dean, Northeast Campus, Susan Zelewski, MD; Brendan M. Boe; and Dean Joshua Wynne, MD, MBA, MPH

Fourth District, Minot Travis J. Waswick, of Minot



Dean Joshua Wynne, Travis Waswick, and Assistant Dean, Northwest Campus, Martin L. Rothberg, MD

Sixth District, Bismarck Jean M. Canham of Bismarck and Andrew M. Mills of Bottineau



Associate Dean, Southwest Campus, A. Michael Booth, MD, PhD; Jean Canham, Andrew Mills, and Dean Joshua Wynne, MD, MBA, MPH

The Fresh Air Report from Tobacco Free North Dakota

As this 64th Legislative Session came to a close (or should we say “sort of,” considering legislators left one bill unresolved), we at Tobacco Free North Dakota (TFND) look back at the 78 days lawmakers convened in Bismarck to reflect on both the successes and the shortcomings toward a healthier North Dakota.



Erin Hill-Oban, TFND Executive Director and TJ Jerke, TFND Lobbyist and Director of Education/Advocacy

TFND’s greatest focuses were on bringing North Dakota’s tobacco taxes more in line with those of our surrounding states and overall national average as well as addressing concerns with some virtually unregulated tobacco products like electronic cigarettes. While many commendable pieces of legislation were passed and signed into law, other bills – bills that would have had significant and lasting impacts on public health – did not survive the full legislative journey to the Governor’s desk.

INCREASING NORTH DAKOTA’S TOBACCO EXCISE TAX

As it stands to date, North Dakota has successfully secured two of three proven strategies in a “three-legged stool” approach to reduce and prevent tobacco use and death. Since 2009, our state’s comprehensive program, which follows CDC Best Recommended Practice, has been fully-funded via a small portion of the tobacco Master Settlement Agreement. And, as of December 2012, we have one of the nation’s strongest smoke-free indoor air laws. However, given our ranking of 46th lowest in the country, (just 44 cents per pack of cigarettes), North Dakota’s dangerously low tobacco tax represents an obvious shortcoming in achieving the third leg of the stool.

To further reduce North Dakota’s tobacco use rates and to save in future health care costs, costs for which every taxpayer pays, TFND worked together with the North Dakota Medical Association, health officials and community, and statewide organizations to increase the state’s tobacco excise tax by supporting two separate, bipartisan proposals, one introduced in each chamber.

HB 1421 was a proposal to raise the state’s tax on a pack

of cigarettes by \$1.10, from 44 cents to \$1.54, equal to the national average, and a proportional increase on other tobacco products. While decreasing current smoking rates and youth’s access to tobacco products was top priority for TFND, the proposal also had an added benefit of producing an estimated \$138 million per biennium in new revenue. The bill was drafted to distribute any new revenue between the state’s Community Health Trust Fund and cities/ counties to assist in health and safety needs.

Despite public support for the proposal (69% of North Dakota voters according to a statewide poll conducted by ACS CAN in December 2014), bipartisan legislative sponsorship, and a valiant effort by the bill’s primary sponsor (Rep. Jon Nelson, R-Rugby), the cards were stacked too high. Ultimately, HB 1421 was given an 11-2 Do Not Pass recommendation by the House Finance & Tax Committee and was defeated on the House floor by a 34-56 vote.

A second bipartisan proposal, introduced in the Senate and championed by Sen. Tim Mathern (D-Fargo), was set to increase the state’s per pack tax by \$1.56 to a total of \$2.00. This bill was estimated to generate \$175 million per biennium but was not written to dedicate revenues, allowing legislators to use this opportunity to fund unmet needs in the state like behavioral and mental health and veterans services or for projects in their communities like domestic violence shelters. Again aimed at decreasing youth access and overall tobacco use in North Dakota, SB 2322 would have had significant positive impacts on public health.

	HB 1421	SB 2322
Proposed Tax Increase (per pack of cigarettes)	\$1.10 (to a total of \$1.54)	\$1.56 (to a total of \$2.00)
Estimated additional revenue generated	\$138/biennium	\$175/biennium
Estimated decrease in youth smoking	15.4%	23.3%
Current youth under age 18 estimated from becoming adult smokers	5,300	7,500
Current adults estimated to quit	5,600	8,000
Estimated savings over 5 years from fewer smoking-caused lung cancer cases	\$910,000	\$1.3 million
Estimated savings over 5 years from fewer smoking-caused heart attacks & strokes	\$1.68 million	\$2.39 million
Estimated savings in long-term health care costs from adult & youth smoking declines	\$213.36 million	\$302.97 million
Final floor votes	House: 34-56 (Failed)	Senate: 17-30 (Failed)

TFND's greatest focuses were on bringing North Dakota's tobacco taxes more in line with those of our surrounding states and overall national average

Though this proposal received an encouraging 4-3 Do Pass recommendation by the Senate Finance & Tax Committee, the legislative life of SB 2322 came to an end by a vote of 17-30 from the full Senate.

The disappointments of legislative defeat have not quieted our commitment to this long overdue cause. Instead, we underscore the fact that, in comparison to the outcome of a bill introduced in the 2013 session to increase the cigarette tax by just 56 cents, we doubled the number of “yes” votes while doubling the proposed tax increase. That is measured progress. In addition, we built a broad coalition unified in support of raising North Dakota's tobacco tax and look forward to strengthening those efforts together in the coming years. §

Protecting North Dakota Youth from Emerging Tobacco Products

TFND, along with other public health officials and organizations, also pressed legislators to address growing concerns amidst the tobacco industry's fast-paced marketing and sales of emerging tobacco products like electronic cigarettes (commonly referred to as “e-cigarettes” or “e-cigs”). From 2011 to 2012 alone, e-cigarette use more than doubled among US middle and high school students. Today, the e-cigarette market generates over \$1.5 billion annually, and as incidence continued to explode leading up to the 2015 legislative session, our state lawmakers were already in a position of playing catch-up to responsibly regulate the new products.

Prior to the convening of this session, lawmakers were educated about the obvious marketing of and easy access youth had to e-cigarettes, a modern spin on an old tobacco product designed only to initiate addiction to those who use them. The issues we outlined with e-cigarettes were undoubtedly recognized and support for making changes was almost universally accepted. What those changes would look like, however, varied.

Three bills regarding e-cigarettes were introduced during this session, each with different degrees of regulations and each deserving of different levels of support from the health and prevention perspective. TFND gauged our support based on which bill provided the most comprehensive approach to regulating an otherwise largely unregulated product.

HB 1078 was the earliest to be introduced (by Rep. Diane Larson, R-Bismarck) and included the most basic of protections advocated by TFND. The bill sponsor was adamant that the language remained simple, and while those efforts were genuine, we insisted on greater protections than HB 1078 offered.

HB 1186 was the second bill filed (by Rep. Kim Koppelman,

R-West Fargo) and, as originally introduced, had earned the support of the tobacco industry and was lacking in far too many details and protections to receive our support as written. The final version of this bill carved out e-cigarettes as a separate classification from other tobacco products in Century Code, something we view as both short-sighted and a special exemption, but it was amended to include many of the important prevention and control policies for which TFND had advocated.

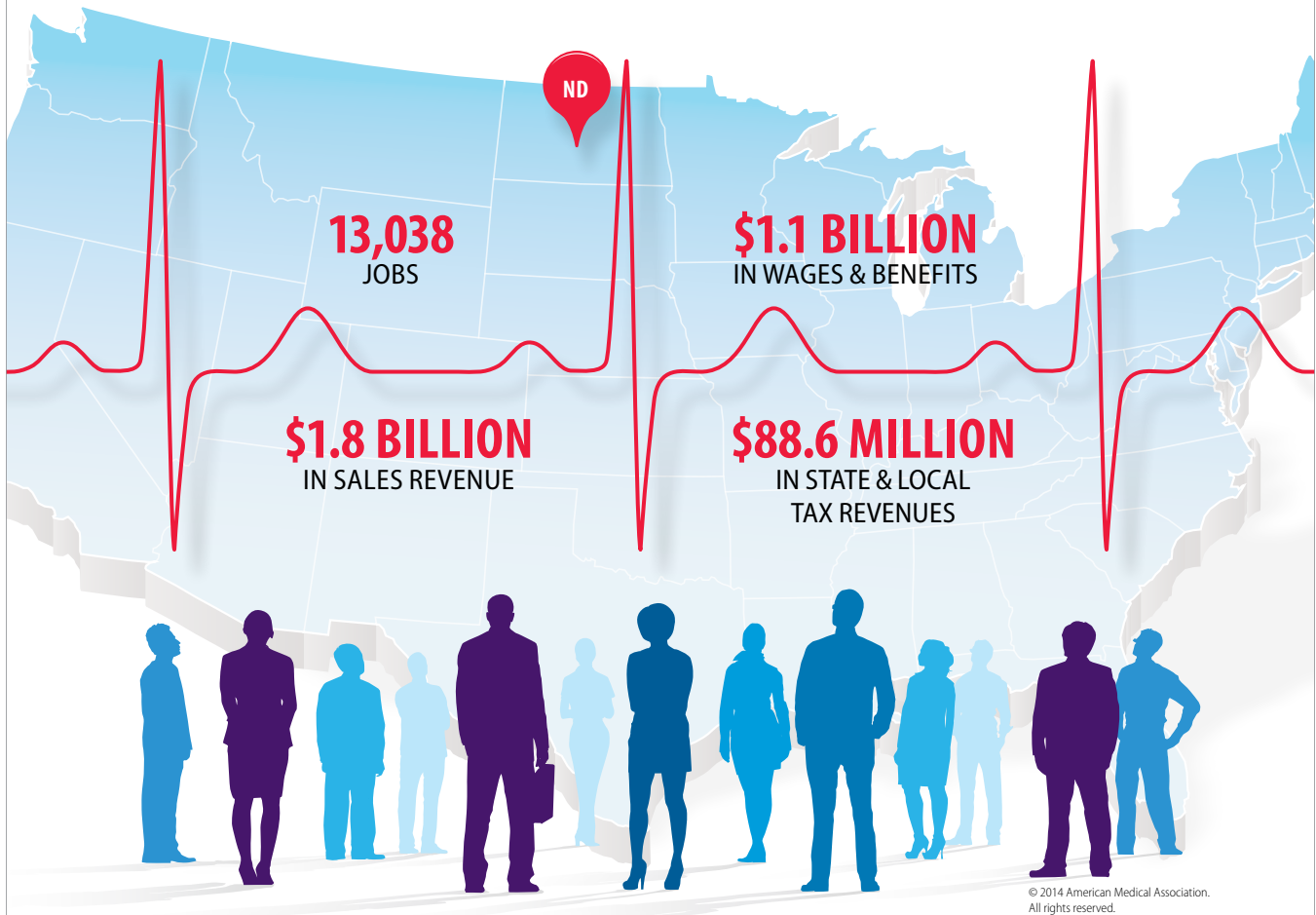
HB 1265 was the final and most comprehensive bill filed (by Rep. Marvin Nelson, D-Rolla) to address our concerns with e-cigarettes. The draft included every policy suggested to truly keep liquid nicotine, e-cigarettes, and all components of these devices out of the hands of North Dakota's youth. Importantly, it would disclose to the public, parents, and community leaders who was licensed to sell e-cigarettes and placed penalties for infractions (like selling to minors) on the retailer (rather than the sales clerk), a more significant deterrent and, therefore, greater protection to minors.

In the end, HB 1186 was the only e-cigarette bill to successfully pass both chambers and be signed into law. While not necessarily the best bill to ensure proper enforcement and the greatest safety for North Dakota's youth, the adopted amendments provided significant improvements to its original version. The law and these new guidelines will take effect on August 1, 2015.

We want to thank the North Dakota Medical Association staff and members for your support of these tobacco prevention legislative efforts and invite you, as always, to continue to take an active role in shaping health policy that affects our state and saves the lives of the citizens who call North Dakota home. §

	HB 1078	HB 1186	HB 1265
Comprehensive e-cigarette definition as “electronic smoking device”	NO	YES - AS AMENDED	YES
Restricts sale/purchase of e-cigarettes to age 18+	YES	YES	YES
Classifies e-cigarettes as tobacco product	NO	NO	YES
Requires child-proof packaging of liquid nicotine	NO	YES - AS AMENDED	YES
Requires behind-the-counter placement of e-cigarettes/components *minimum requirement of locked display cases	NO	NO*	YES
Requires tobacco retailer license to sell e-cigarettes	NO	NO	YES
Penalty for sale to minor	EMPLOYEE	EMPLOYEE	RETAILER
Final floor votes	House: 51-40 (Passed) Senate: 9-37 (Failed)	House: 71-20 (Passed) Senate: 46-0 (Passed)	House: 37-54 (Failed)

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.



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
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LOCAL & STATE TAX REVENUE

Total Local & State Tax Revenue Generated by Physicians ¹	\$ 88.6 Million	\$ 65.2 Billion
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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

UND School of Medicine and Health Sciences Recognizes Volunteer Faculty

The University of North Dakota School of Medicine and Health Sciences presented the Dean's Special Recognition Awards for Outstanding Volunteer Faculty to the following physicians during commencement ceremonies on Saturday, May 9, 2015.

- Aaron J. Chalmers, MD, Clinical Instructor of Surgery and alumnus, MD Class of 2007, Bismarck, ND
- Siri J. Fiebiger, MD, MPH, Clinical Assistant Professor of Obstetrics and Gynecology and alumna, MD Class of 1985, Fargo, ND
- Rena Nordeng Zimmermann, MD, Clinical Assistant Professor of Family and Community Medicine and alumna, MD Class of 2007, Dickinson, ND
- Jennifer M. Peterson, MD, Clinical Assistant Professor of Pediatrics and alumna, MD Class of 1997, Grand Forks, ND
- Nasser Saffarian, MD, Clinical Assistant Professor of Internal Medicine, Minot, ND
- Gary L. Wease, MD, Clinical Assistant Professor of Surgery Minot, ND
- Ryan M. Zimmermann, MD, Clinical Assistant Professor of Family and Community Medicine and alumnus, MD Class of 2007, Dickinson, ND



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

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

Rep. Cramer visits The Bone and Joint Center



Pictured are: Representative Cramer, Chad Carlson, MD; Tim Juelson, MD; and Joe Carlson, MD.

On Friday, May 22, Congressman Kevin Cramer visited The Bone and Joint Center in Bismarck. While there, Representative Cramer joined Dr. Juelson during some patient checkups, talked with the staff, and toured the same-day surgery facility at Bismarck Surgical Associates.

Beaming after the Beam Signing

As with any monumental construction project, commemorative rituals take place. The UND SMHS Advisory Council signed a beam that will be placed into the new building, along with Representative Kevin Cramer, community members, and UND SMHS supporters.



Pictured from left to right are: back row: Dean Joshua Wynne, MD, MBA, MPH; Senator Bob Erbele, District 28; and Dave Molmen, CEO, Altru Health Systems; middle row: Breton Weintraub, MD, FACP, Chief of Staff, Fargo VA Healthcare System; Stephen Tinguely, MD, Chair, Department of Pediatrics, UND SMHS; Kevin Melicher, DO, Eyecare Associates PC, Fargo; Tom Arnold, MD, St. Joseph's Women's Clinic, Dickinson; Courtney Koebele, JD, NDMA Executive Director; and Brad Gibbons, MPA, Acting Director, Center for Rural Health (standing in for Gary Hart); front: Maggie Anderson, Executive Director of the Department of Human Services; and Senator Tim Mathern, District 11.

First District Medical Society Announces Election Results

On May 19, 2015, Julie M. Johnson, MD, was elected to serve as president of the First District Medical Society, one of the eleven medical society chapters of the North Dakota Medical Association. The First District Medical Society encompasses the largest and most active district in the state (Cass, Ransom, Richland, and Sargent counties). Johnson, a graduate of the University of Nevada Medical School in Reno, Nevada, completed her residency at Michigan State University in Grand Rapids, Michigan, and she currently practices as an orthopedic surgeon at Essentia Health. Dr. Johnson will join the other elected physicians as part of the First District's leadership team: Neville Alberto, MD; Stephanie Dahl, MD; Fadel Nammour, MD; and Osama Naseer, MD (NDMA councillors); Mary Aaland, MD (secretary-treasurer); and Jau-Shin Lou, MD (vice president).



Get involved with your district, or at least attend the socials for some good food and company! Here are some upcoming meetings:

District 8 Medical Society Meeting: Tuesday, June 16 in Williston

District 6 Medical Society Meeting: Tuesday, August 18 in Bismarck

Contact the NDMA office at 701-223-9475 for more information about your district medical society.

SUPPORT NDMA PAC!



The North Dakota Medical Association Political Action Committee (NDMA PAC) advocates on your behalf regarding crucial issues you encounter on a daily basis.

Politics have become more deeply embedded in the daily practice of medicine, which requires physicians to become more involved in the political process. Without active and engaged involvement, the voice of the physician community will not be heard or understood. The NDMA PAC places a crucial role in these efforts through intentional action and advocacy. However, without your support, we will not have the necessary financial resources available to support candidates who are proven friends of medicine.

Your time is valuable and joining NDMA PAC is the quickest, easiest, and most effective way to make your voice heard in the political process. Please consider supporting your NDMA PAC with a financial gift today!



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.



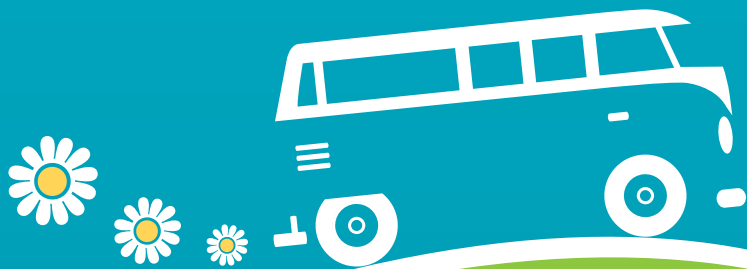
For more questions, please visit docbookmd.com or you can contact us at 888-930-2048 or info@docbookmd.com.
The Care Team feature is only available with the latest app version of 5.0.



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NDMA
NORTH DAKOTA MEDICAL ASSOCIATION

**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.

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



2015

Events Calendar

June 2-4, 2015

Dakota Conference on Rural and Public Health
Minot, ND
Contact Kylie Nissen at
701-777-5380 for information

June 6-10, 2015

AMA Annual Meeting
Hyatt Regency Hotel
Chicago, IL

June 16, 2015

8th District Medical Society Meeting
Williston, ND
Call 701-223-9475 for information

June 25, 2015

North Dakota HIMSS Spring Conference
Hilton Garden Inn
Fargo, ND
Contact Quaya Ackerman at 701-234-3447 for
information

August 4-6, 2015

AMA State Advocacy Roundtable
Park Hyatt Aviara Resort
Carlsbad, CA

August 18, 2015

6th District Medical Society Meeting
Bismarck, ND
Call 701-223-9475 for information

August 21-22, 2015

North Dakota Society of Obstetrics and
Gynecology
Community Center
Medora, ND
For more information,
contact Dennis Lutz, MD
at 701-852-1555

September 16-18, 2015

North Dakota Long Term Care Association Fall
Professional Development Conference
Ramkota Hotel and Civic Center
Bismarck, ND
[Click here for information](#)

September 25, 2015

NDMA Annual Meeting
National Energy Center of Excellence,
Bismarck State College
Bismarck, ND
For more information,
contact the NDMA office
at 701-223-9475

October 6-8, 2015

North Dakota Hospital Association Annual
Meeting
and Trade Show
Hilton Garden Inn
Fargo, ND
[Click here for information](#)

November 14-17, 2015

AMA Interim Meeting
Atlanta Marriott Marquis
Atlanta, GA

December 3-6, 2015

AAAP 2015 Annual Meeting
Hyatt Regency Huntington Beach Resort and
Spa
Huntington Beach, CA
[Contact AAAP for information](#)