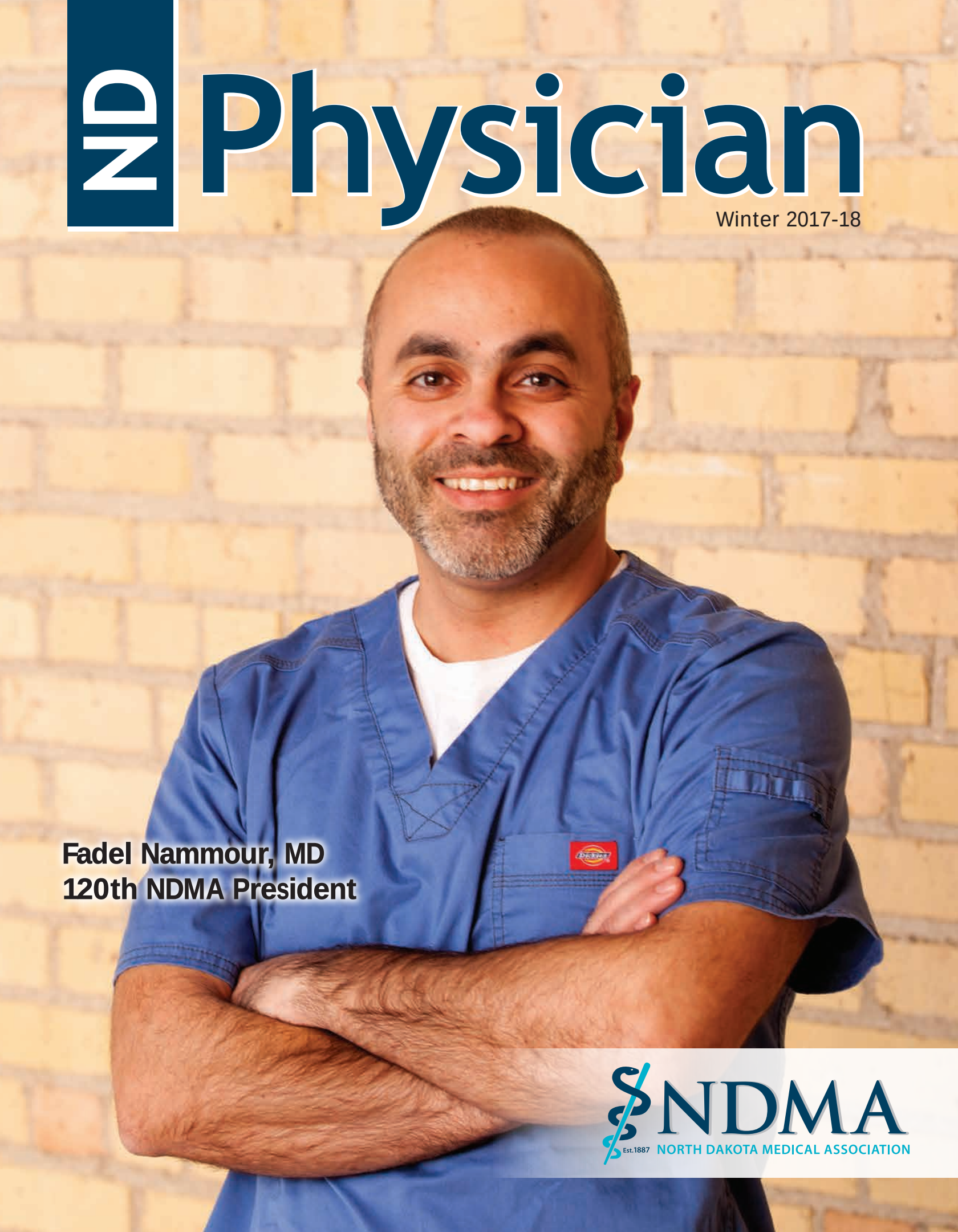
ND Physician

Winter 2017-18



Fadel Nammour, MD
120th NDMA President

NDMA
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ND Physician

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The mission of the North Dakota Medical Association is to advocate for North Dakota's physicians, to advance the health, and promote the well-being of the people of North Dakota.

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

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In this Issue

President's Message

Healthcare is Complicated

Fadel Nammour, MD
NDMA President

As president of NDMA, I am honored to serve in this leadership role to help North Dakota physicians provide high quality care for patients. I look forward to being part of the solution that will help drive positive healthcare changes, and encourage all physicians to become involved. If you are reading this, you've already taken the first step. Together, we can make a difference as we work to resolve some very complicated issues surrounding healthcare.

"Healthcare is complicated." This statement was made famous this year after our President saw the challenge of healthcare in the United States first hand. A sentiment shared not only by politicians, the sick and the healthy, but also by healthcare professionals.

"Healthcare is complicated." In 2016, health care expenditures in the United States, reached 17.8 percent of gross domestic product which is the equivalent of $9,900 per person, more than twice the average of developed countries. Moreover, all of this money spent does not reflect better outcomes for patients or better quality of life compared to other countries.

"Healthcare is complicated." It took close to 50 years to enact another major healthcare legislation after Medicare and Medicaid in 1965. The Patient Protection and Affordable Care Act (aka Obamacare) provided coverage for millions more Americans and dropped uninsured rates to the lowest levels in history. However, coverage did not necessarily mean access because millions of Americans were left without health care due to increased premiums and higher deductibles. Notably, efforts to repeal and replace Obamacare with a "much better" and "much less expensive" plan failed due to concerns about loss of coverage and fundamental changes to Medicaid financing. The proposed changes could have resulted in block grants or per capita allocation, which may have ended up moving the financial burden from the federal government to the states and, consequently, cutting down reimbursement for hospitals and physicians, eliminating some of the essential benefits currently in place, restricting coverage, and eventually leading to increased costs.

"Healthcare is complicated." We live in a pill-popping culture where corporations, pharmaceutical companies and sadly sometimes with the help of health care professionals promote the adage "a pill or a device for all illness." Unfortunately, we live in an instant gratification society where patients demand instant relief and too often we get drawn into giving it to them in the form of a pill, a surgery or a

procedure instead of considering any behavior modification tools or lifestyle changes.

"Healthcare is complicated." Physicians and other healthcare professionals are feeling the burnout. Tragically, close to 50 percent of physicians are experiencing burnout at any given time with one of the highest suicide rates of any profession. Burnout is related, but not limited to time pressure, productivity quotas, electronic medical records, patient satisfaction surveys, accountability and all the regulations imposed by third parties like insurance companies, healthcare systems, government and certifications of licensing boards. It has become not only a physical burnout, working sometimes more than 80 hours a week, but an emotional state where we feel we have no control and fall short to meet expectations.

"Healthcare is complicated." Despite all of the pressures, every year in the state of ND, more than 70 medical students join the University of ND School of Medicine and Health Sciences and take the Hippocratic oath to heal and comfort the sick and disabled. To put it differently, the healthcare profession is still a rewarding vocation which needs to be held sacred and protected. For this reason, it's our job to advocate for a better work environment, more autonomy and fair reimbursement. Additionally, encouraging dynamic collaboration with all parties is essential towards preserving an unbiased physician-patient relationship.

To our members, thank you for your involvement and thank you for electing me president of NDMA. Since 1887, NDMA has ensured that physicians have a strong, independent voice on policy issues, which impacts physicians and patient care. To keep this organization strong, I encourage all members to reach out to physician colleagues and ask them to become involved. As physicians, we have a great deal at stake. As president, I look forward to serving you and making our goals a reality.

Fadel Nammour, MD, FACG, FACP was elected president of the North Dakota Medical Association on October 6, 2017. He obtained his medical diploma from St Joseph's University Medical School, Beirut, Lebanon. In 1996, he moved to the United States and completed his internship in internal medicine at Union Memorial Hospital, Baltimore, MD. He then finished his residency in internal medicine and pursued a fellowship in Gastroenterology at UMDNJ-Cooper Hospital, Camden, NJ. He has practiced in the Fargo-Moorhead area since 2002, and he is also a fellow with the American College of Gastroenterology (ACG) and American College of Physicians (ACP). He is currently ND ACG governor and serves as chair of the ND Colorectal Cancer Roundtable. Dr Nammour was appointed to the ND Medical Advisory Board in 2017. He practices as solo gastroenterologist and owns Dakota Gastroenterology Clinic located in Fargo, ND. Dr. Nammour and his wife Heidi live in West Fargo, ND, with their three sons.

The 2017 Legislative Session: A Successful Session

Courtney M. Koebele, JD
NDMA Executive Director

The 65th North Dakota Legislative Assembly met for 77 days, adjourning on April 27. During the four-month session, NDMA worked alongside other groups and organizations to champion the legislative agenda that NDMA members adopted in the fall of 2016. NDMA was there each and every day representing your interests and the interests of your patients.

Personal Wellness Assessment Program

In addition to the legislative action, NDMA was proud to be involved with other happenings on the hill. On February 1 and 2, James Brosseau, MD, with assistance from Kim Krohn, MD of Trinity Health, Minot, and Altru Health System staff members, coordinated a Personal Wellness Assessment program in The Great Hall for legislators and legislative staff. The program was well-received during the previous four sessions, and this year was no different. We greatly appreciated Dr. Brosseau and Dr. Krohn's efforts, as did the over 200 individuals who took advantage of the assessment.

Doctor of the Day

The Doctor of the Day program was well received in the 2017 Legislature. Physicians who participated in the program were: Douglas Berglund, MD; James Brosseau, MD; Kwanza Devlin, MD; Debra Geier, MD; Jeff Hostetter, MD; Ted Kleiman, MD; Kimberly Krohn, MD; Brian O'Hara, MD; Shari Orser, MD; Jacqueline Quisno, MD; Shannon Sauter, MD; Sarah Schatz, MD; Guy Tangedahl, MD; Daniel Tuvin, MD; Michael Walery, MD; Karin Willis, MD; Dennis Wolf, MD; and Joshua Wynne, MD.

The 2017 NDMA Doctor of the Day Program kicked off on January 16 and continued through the session. Not only did it provide a service to our legislators, but it also afforded the volunteer doctors an excellent opportunity to observe the 2017 ND Legislative Assembly in action. As the Doctor of the Day, the volunteer physician provided primary care services to legislators and staff on the premises, where basic exam equipment and OTC medications were available. Some physicians experienced a packed schedule and others could observe the legislative session while carrying a pager.

Physician and Hospital Day

As in the previous two sessions, NDMA teamed up with the North Dakota Hospital Association and the North Dakota Emergency Medical Services Association for the Physician and Hospital Day on Tuesday, January 31, 2017. This year's event also included participation from the ND Academy of Physicians Assistants and the ND Academy of Family Physicians. The event provided a face-to-face opportunity for physicians to discuss priority issues with legislators, attend bill hearings, and get to know their legislators over a lunch. The highlight of the day was having NDMA supporters and members pack the Senate Human Services Committee hearing room in opposition to the expansion of scope of naturopaths. The bill was defeated, and we credit NDMA members and supporters for the defeat! We look forward to co-hosting the next Physician and Hospital Day in 2019.

Accomplishments

NDMA is proud of its accomplishments through the session and proud of the strong relationships NDMA has with other lobbying groups, legislators, and constituents. This was a successful session and NDMA stands by the work accomplished. Things can change quickly at the Capitol, so NDMA is proud that we can dedicate an incredible amount of time to the session, before and after hours. And thanks to all of you that volunteered your time and expertise to move positive legislation forward. The next session is only a short 13 months away- let the countdown begin!

NDMA followed 136 bills, and some are noteworthy because of their impact on the profession of medicine: First is the amazing fact that the 2017 legislature approved Medicaid Expansion HB 1012. Medicaid Expansion, approved by the North Dakota Legislature in 2013, covers 20,000 North Dakota lives under the age of 65 with incomes below 138 percent of the

federal poverty level. It provides access to affordable care for working North Dakotans who make too much to qualify for traditional Medicaid, but not enough to qualify for health insurance subsidies. *Without the state investment in Medicaid Expansion, North Dakota loses this economic generator with trickle-down impacts to communities, businesses, and individuals.* The economic impact to ND hospitals and physicians is estimated to be 190 million per year. NDMA supported Medicaid expansion continuation into the 2017-2019 biennium at commercial rates. Both the House and the Senate agree with continuing Medicaid expansion. HB 1012 passed by both Houses with Medicaid expansion at the commercial rates for all North Dakota providers. ***I can sum up why Medicaid expansion was passed in one number – $586 million in federal funds. That is what Medicaid expansion brings to the North Dakota health care system over the next biennium.***

Unfortunately, the legislature did not reverse the drastic 30 percent cut in Medicaid payments that was instituted during the allotment process in February 2016. That means Medicaid payments to physicians were reduced to 2008 levels. NDMA supports sustainable payments to providers and testified in support of reinstating the allotment and inflationary increases. Health care operates on a fixed reimbursement system, meaning providers cannot increase charges to offset increasing labor costs. Reimbursement rates must be equitable to the cost of care. Unfortunately, with the budget situation, the allotment was not restored. North Dakota Medicaid rates remain at Medicare levels. This makes North Dakota still among the highest in the nation – and therefore our argument to increase is quite difficult.

NDMA supports sustainable payments to providers and testified in support of reinstating the allotment and inflationary increases.

Another big dispute was the Medicaid Prior Authorization of Adult ADHD Medications HB 1120: This bill proposed to change the Medicaid prior authorization statute to allow the state to prior authorize generic when brand name is less expensive; to allow the state to prior authorize ADHD medication in adults AND require a consult with the department when a child was on five or more psychotropic medications. Based on objections received in the House, *the bill was amended, the prior authorization was removed, and the other two portions passed.*

UND School of Medicine and Health Sciences SB 2003: In the last three sessions, the North Dakota Legislature adopted the School's Health Care Workforce Initiative (HWI) to address the health care provider needs of North Dakota now and in the future. *In 2011, 2013 and 2015 the legislature granted 16 new residency slots, 16 more medical students, and 30 additional health science students, and a new medical school building to house all health science students.* To maintain this excellent work, the Medical School needed adequate funding in addition to the Governor's submitted budget. NDMA supports UND SMHS in its pursuit of greater retention of graduates and increasing the number of providers in the state. *The Medical School did secure sufficient funding to maintain its residencies and the full HWI in the 2017-2019 budget.*

Telemedicine SB 2052: In the 2015 session, a bill was passed regarding telemedicine for the Public Employee Retirement System (PERS). The bill required that telemedicine be covered if in-person services were covered. *In 2017, the feedback from PERS was that it was a positive change and increased access and the legislature passed the bill to apply to all insurance providers. The law now contains "coverage parity" for all health insurers in the state.*

NDMA/NDNA Joint Venture: Assault Against a Health Care Provider SB 2216: The original bill, as proposed by NDMA and the ND Nurses Association, contained increased penalties for assault, simple assault and bodily fluid assault against health care providers. The Senate removed the two assault provisions and kept the bodily fluids portion. The House added in first responders in any location. The conference committee decided to include first responders, but only if responders are located in the health care facility. *The bill passed both houses, which now makes it a class C felony if the individual knowingly causes the contact with bodily fluids against a health care facility employee or emergency responder, and is a class A misdemeanor if the individual recklessly causes the contact.*

Interstate Medical Licensure Compact SB 2235: This bill was supported by NDMA; however, it did not pass. The Federation of State Medical Board's Interstate Medical Licensure Compact complements the existing licensing and regulatory authority of state medical boards, and provides a streamlined process that allows physicians to become licensed in multiple states. The compact creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act. The compact has been adopted by 18 states, including Montana, South Dakota, Minnesota, and Iowa. *The bill unanimously passed the Senate with the support of NDMA, the ND Hospital Association, Sanford Health, and Essentia Health. Unfortunately, the ND Board of Medicine was opposed to the compact, and it failed in the House.*

Expansion of Scope for Naturopaths SB 2256: This bill was NOT SUPPORTED by NDMA, and was successfully defeated. Naturopaths, licensed in North Dakota in

2011, attempted to expand their scope of practice in 2015 to include prescribing, office procedures and midwifery. This attempt was defeated in 2015 and the identical bill was filed in 2017. *Organized medicine continues its opposition because naturopaths are not trained adequately to prescribe medications.* Naturopaths have no requirement of residency and don't take the same courses or tests as physicians. The board licensing naturopaths does not have the capability of regulating this type of scope of practice. *NDMA vigorously opposed this bill in 2017* and it was changed into a midwifery study by the Senate. The study failed in the House.

AARP Care Act SB 2215 and HB 1039: These well-intentioned bills were filed in both the Senate and the House. *Both versions failed.* The bill would have required that hospitals specifically document caregivers and the instructions given to both the patient and the caregiver prior to discharge. The hospitals objected to the bill, in that they have specific requirements under their conditions of participation with Medicaid and Medicare. The concern about the bill was that it would create liability concerns and delay discharge in many cases. The policy makers agreed and defeated the bills.

EMS Personnel SB 2312: The passage of this bill now allows licensed advanced emergency medical technicians and paramedics who are employed by hospitals to provide the patient care within a scope of practice established by the North Dakota Department of Health. This allows EMS professionals to work under the reporting structure that works best for the hospital. Under this section, these emergency medical services professionals must be supervised by a hospital designated physician, physician assistant, advanced practice registered nurse, or registered nurse.

Forced Medication in Guardianship Cases HB 1365 and SB 2291: Two bills were filed dealing with medication in guardianship cases. The issue arose when a ward was in the state hospital and because of the state law, medical personnel would have to go to court for every medication that the ward refused. Private facilities generally respected the appointed guardian's decision. The change in the law allows for the appointed guardian to make those decisions, based on recommendation from the treating PA, NP, or physician.

Expert Examiner in Guardianship Cases HB 1095: A bill was proposed to enlarge the group of providers that can provide examinations in guardianship cases by enlarging the definition of physician to include APRN and psychologist. *Based on strong objections by NDMA, the*

bill was amended to change the term to "expert examiner" and allow APRN, PA and physicians do examinations for the court in guardianship cases. The amendments were supported by both houses, and passed.

Air Ambulance SB 2231: Based on complaints about air ambulance balance billing, the insurance commissioner filed this bill to limit the charges for air ambulances. The new law requires that in non-emergency situations, before a hospital refers a patient to an air ambulance service, the hospital will inform the patient of the air ambulance service provider's health insurance network status for the purpose of allowing the patient to make an informed decision on choosing an air ambulance service provider.

Medical Marijuana SB 2344: This bill is the legislative revision of Measure 5, which passed in November authorizing medical marijuana in North Dakota. The bill was passed by a 2/3 majority in each house, which is the requirement to change the initiated measure. The new law decriminalized the growing, manufacturing, dispensing, possession and use of marijuana for medical purposes (the original measure failed to do this). The law eliminates the ability of qualifying patients and designated caregivers to grow their own marijuana for medical use. This was an important, but disputed part of the bill, because the request of law enforcement entities had to be balanced against the wishes of the measure proponents.

One important medical marijuana requirement for physicians to consider is the ***bona fide provider-patient relationship for certification.*** This means there must be a treatment or counseling relationship between a provider (Physician or APRN) and patient that includes the following:

- The health care provider has reviewed the patient's relevant medical records and completed a full assessment of the patient's medical history and current medical condition, including a relevant, in-person, medical evaluation of the patient.
- The health care provider has created and maintained records of the patient's condition in accordance with medically accepted standards.
- The patient is under the health care provider's continued care for the debilitating medical condition that qualifies the patient for the medical use of marijuana.
- The health care provider has a reasonable expectation that provider will continue to provide follow-up care to the patient to monitor the medical use of marijuana as a treatment of the patient's debilitating medical condition.
- The relationship is not for the sole purpose of providing written certification for the medical use of marijuana.

The ND Department of Health's Division of Medical Marijuana is responsible for establishing and implementing the medical marijuana program in North Dakota. On November 6, the department released proposed rules and are expecting to file rules to the legislative Administrative Rules Committee in March. If the committee approves the rules in March, the earliest they could be finalized is April 1.

Since 1887, NDMA has ensured that physicians have a strong, independent voice on issues that impact physicians and patients. Please call the NDMA office if you have any questions on these or any upcoming legislative issues.

An Update on the Prescription Drug Monitoring Program (PDMP) and Increased Utilization in Practice

Mark Hardy, PharmD
Executive Director
North Dakota Board of Pharmacy

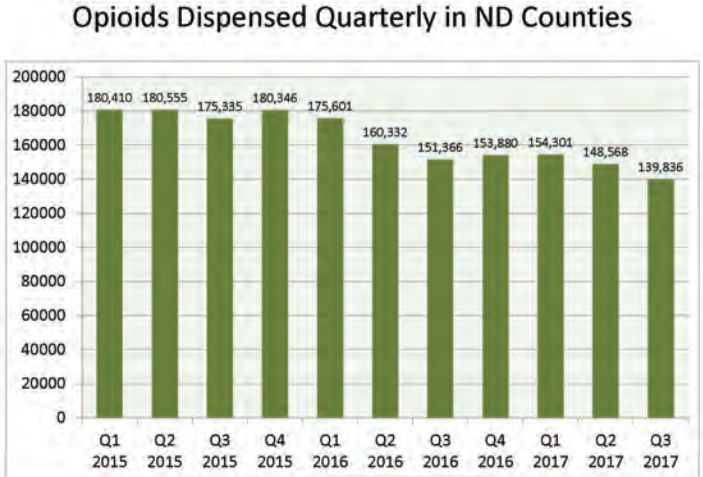
The Prescription Drug Monitoring Program (PDMP) has been operational in North Dakota since 2007. With the recent increase in deaths that are attributed to opioids in the state, the PDMP continues to be the most powerful clinical tool for prescribing practitioners, pharmacists, law enforcement and treatment specialists in the North Dakota fight against the opioid epidemic.

As the administrative boards have passed rules governing the use of the PDMP in each profession, we have seen the rapid escalation in the utilization of the PDMP. To keep the program working as effectively as possible, the Advisory Committee made the decision to implement even stronger requirements by changing the threshold of prescriber alert levels from six to three. This means that prescribers are alerted on patients who see three or more prescribers, and/or three or more dispensers in a three-month time period. This change reduces the large window so that prescribers are seeing reports on more recently seen patients.

The ND Board of Medicine is also moving toward finalizing PDMP standards for their licensees. As the licensees prepare for the upcoming changes, we are seeing a rapid increase in the utilization of the PDMP by the prescribing physicians.

Some healthcare systems across the state are already integrating their electronic health records systems into the PDMP system, to make accessing a patient's profile easier. Our office is ready and able to assist in facilitating those connections if the health system chooses to move forward with this enhancement for their prescribers. We encourage all prescribers to sign up with the PDMP now, because when the Board of Medicine rules become enacted, all prescribers will be required to have access to PDMP. This will not only ensure compliance with the rules, but also ensures that you have access to this important clinical tool in your practice. As has always been the PDMP's practice, we allow delegates to access PDMP profiles on a practitioner's behalf to aid in streamlining workflow in your individual practices.

We encourage all prescribers to sign up now to access PDMP.



The Prescription Drug Monitoring Program (PDMP) reports that state-wide opioids dispensed by North Dakota pharmacies have been steadily decreasing each quarter since 2015.

ND Dept. of Human Services Opioid Treatment and Addiction Prevention Strategy: How it Works

Prescription drug and opioid abuse is an emerging concern in North Dakota. Approximately 14.5 percent of North Dakota high school students reported using prescription drugs without a prescription one or more times during their lifetime (YRBS, 2015). Overdose deaths in North Dakota increased from 20 deaths in 2013 to 61 deaths in 2015 (CDC/NCHS, National Vital Statistics System, Mortality).

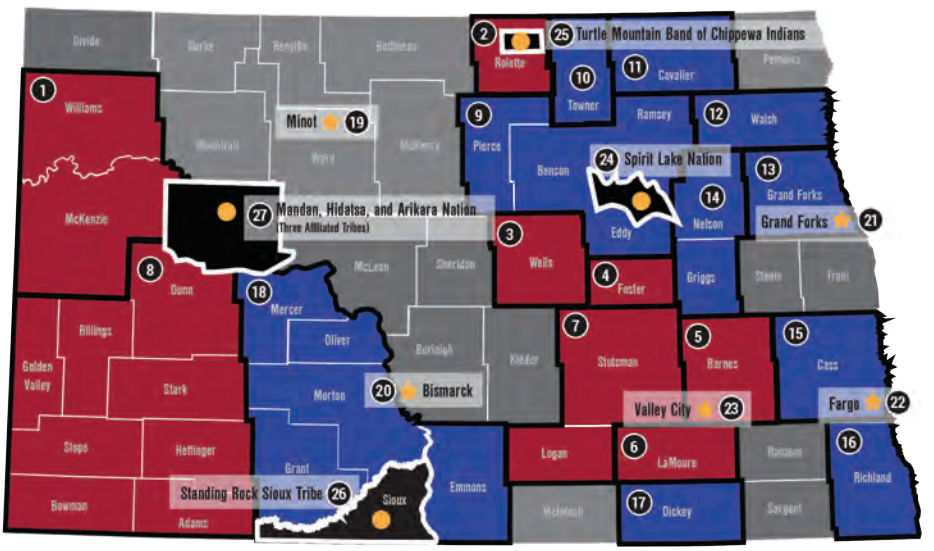
The Substance Abuse Mental Health Services Administration (SAMHSA) notified North Dakota of the awarded one-year State Targeted Response to the Opioid Crisis Grant (Opioid STR) in April 2017. North Dakota received $2 million to address gaps and build upon existing statewide efforts and infrastructure by increasing access to evidence-based treatment and recovery services for opioid use disorder and reducing opioid overdose related deaths through the provision of primary and secondary prevention. The grant ends April 30, 2018.

The first goal of North Dakota's Opioid STR is to increase evidence-based treatment and recovery services for individuals with Opioid Use Disorder (OUD), with a focus on individuals reentering communities from criminal justice settings. The summarized objectives were identified to achieve this goal: (1) increase utilization of Medication-Assisted Treatment (MAT); (2) Increase access to peer and other evidence-based recovery support services.

The second goal is to increase implementation of evidence-based primary and secondary prevention strategies. The summarized objectives were identified to achieve this goal: (1) decrease access to unneeded prescription opioid medication; (2) increase availability and utilization of naloxone.

Substance Abuse Prevention Community Funding Distribution

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES' BEHAVIORAL HEALTH DIVISION



Pamela Sagness
Behavioral Health Division Director
North Dakota Department of Human Services

The third goal is to increase utilization of effective treatment services for OUD by increasing communication efforts to reduce stigma surrounding OUD, MAT and syringe service programs.

To address North Dakota's capacity needs regarding the opioid crisis and to effectively implement evidence-based strategies across the full continuum of care, the North Dakota Behavioral Health Division developed a hybrid system design to implement evidence-based strategies that will most rapidly address needs and gaps at both the state and community levels.

To implement the proposed hybrid approach at the community level, the North Dakota Behavioral Health Division is currently funding five communities and four tribes across the state to increase access to treatment, reduce unmet treatment needs, and reduce overdose-related deaths through the implementation of evidence-based prevention, treatment, and recovery activities.

In order to impact the opioid crisis across the state, a "Champion Prescriber" is in contract to provide outreach across the state to hospital and clinic administrators, prescribers, correctional administrators, and behavioral health treatment

providers to enhance policies regarding the prescribing and utilization of medications used to treat opioid use disorder and overdose.

To further support prescribers engaging in medication assisted treatment, the North Dakota Behavioral Health Division is in contract with the University of North Dakota, Center for Rural Health to create a prescriber hub and spoke knowledge-sharing network, using the Project ECHO (Extension for Community Healthcare Outcomes) model. The model creates collaboration between a specialist medical team and prescriber across the state providing medication assisted treatment to individuals with opioid use disorder. This collaboration will use technology to reach rural prescribers to share best practices, provide support, and apply case-based learning.

As research indicates, individuals with an OUD who have a period of abstinence or a recent non-lethal overdose are at high risk of returning to opioid use and experiencing an overdose. To address this, a target audience for the state's implementation of the Opioid STR is individuals being released from both state and county correctional settings. The North Dakota Behavioral Health Division is contracting with the Department of Corrections and Rehabilitation to increase access to medication assisted treatment and increase overdose prevention strategies for individuals with an opioid use disorder re-entering the community.

For more information on grant-funded efforts and other resources related to opioid use disorder and overdose, visit *https://behavioralhealth.dhs.nd.gov/addiction/opioid.*

NORTH DAKOTA BEHAVIORAL HEALTH

SUD VOUCHER

Substance Use Disorder Voucher

The SUD Voucher supports eligible individuals in their personal recovery by reducing financial barriers in accessing substance use disorder treatment and recovery services.

Accessing the SUD Voucher

How do I apply?

To apply contact a participating SUD Voucher provider or a Regional Human Service Center for assistance on completing and submitting an application.

For an updated list of the participating SUD Voucher providers, please call **701.328.8920** or go to **www.nd.gov/dhs/services/mentalhealth** and click on the SUD Voucher icon.

Eligibility

1. The individual resides in North Dakota
2. The individual is 18 years of age or older
3. A licensed professional determined the individual is in need of a service
4. A Release of Information (ROI) is signed for the Department of Human Services' Behavioral Health Division (BHD) to access treatment and financial records
5. The individual does not have resources to pay for treatment and one of the following:
   a. The individual's third party payment resource will not cover all costs of treatment; or
   b. The individual has a pending application for medical assistance which presents a barrier to timely access to treatment; or
   c. The individual does not qualify for medical assistance and has no alternative third party payment resources
6. The individual has an annual income no greater than 200% of federal poverty guidelines:

HOUSEHOLD SIZE	200%
1	$23,540
2	$31,860
3	$40,180
4	$48,500
5	$56,820
6	$65,140
7	$73,460
8	$81,780

If an individual has a need for the SUD Voucher but does not meet these requirements, an exception form can be submitted to the BHD.

Covered **Services**

Participating SUD Voucher providers may provide one or more of the following services:

- Screening
- Assessment
- Individual Therapy
- Group Therapy
- Family Therapy
- Room & Board
- Recovery Coach
- Urine Analysis
- Transportation

SUD Voucher Providers

With the passage of Senate Bill 2048 during the 64th Legislative Session the Department of Human Services (DHS) was appropriated funding to administer a voucher system to pay for substance use disorder treatment services. The Department's Behavioral Health Division (BHD) was assigned the responsibility to develop administrative rules and implement the voucher system.

	Screening	Assessment	Individual Therapy	Family Therapy	Outpatient Treatment (ASAM I)	Intensive Outpatient Treatment (ASAM 2.1)	Partial Hospitalization/ Day Treatment (ASAM 2.5)	Room & Board	Recovery Coaching	Transportation	Methadone Maintenance
Community Medical Services - Fargo	X	X	X							X	X
Community Medical Services - Minot	X	X	X							X	X
Drake Counseling Services	X	X		X	X	X	X				
First Step Recovery	X	X	X	X	X	X	X		X	X	
Heartview Foundation - Bismarck	X	X	X	X	X	X	X	X	X	X	X
Heartview Foundation - Cando	X	X	X	X	X	X	X	X	X	X	
Prairie St John's	X	X		X	X	X	X	X		X	
ShareHouse Inc.	X	X	X	X	X	X	X	X	X	X	
St. Thomas Counseling Center, PLLC	X	X	X	X	X	X				X	

For additional information about the providers please contact them at:

Community Medical Services - Fargo
901 28th Street South
Fargo, ND 50103
701.404.1101

Community Medical Services - Minot
300 30th Ave NW Suite D
Minot, ND 58701
701.858.1801

Drake Counseling Services
1202 23rd Street South
Fargo, ND 58103
701.293.5429

First Step Recovery
3201 Fiechtner Drive
Fargo, ND 58103
701.293.3384

Heartview Foundation Bismarck
101 E Broadway Ave
Bismarck, ND 58501
701.222.0386

Heartview Foundation Cando
7448 68th Ave. NE
Cando, ND 58324
701.968.4056

Prairie St John's
510 4th Street South
Fargo, ND 58103
701.476.7221

ShareHouse Inc.
505 40th St S
Fargo, ND 58103
701.282.6561

St. Thomas Counseling Center, PLLC
108 1st Ave. South, Suite 300
Jamestown, ND 58401
701.952.7555

Treatment Centers Offer Program to Train More Buprenorphine Prescribers

Kurt Snyder
Executive Director
Heartview Foundation

The Heartview Foundation and Community Medical Services have partnered to expand access to Medicated Assisted Treatment (MAT) in North Dakota through the development of a Hub and Spoke Model of Care. Heartview operates an Opioid Treatment Program (OTP) in Bismarck and Community Medical Services operates an OTP in Minot and Fargo.

Each Opioid Treatment Program location will serve as a hub with "champion prescribers" available to recruit prescribers across North Dakota to become eligible buprenorphine prescribers in an office-based setting (SPOKES). In conjunction with Project ECHO (Extension for Community Healthcare Outcomes), ***the champion prescribers will coach and mentor newly DATA (Drug Addiction Treatment Act) waived prescribers on MAT and overdose prevention and provide ongoing support.***

Newly DATA waived prescribers will be eligible to receive $1,000.

Newly DATA waived prescribers will be eligible to receive a $1,000 stipend from the ND Department of Human Services, Behavioral Health Division.

WHAT IS DATA?

Under the Drug Addiction Treatment Act of 2000 (DATA 2000), in order to prescribe or dispense buprenorphine, physicians must qualify for a physician waiver, which includes completing eight hours of required training, and applying for a physician waiver: learn more here: *www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management.*

WHAT IS AN OPIOID TREATMENT PROGRAM (OTP)?

An OTP is a treatment program designed to provide medication-assisted treatment for individuals diagnosed with an opioid use disorder. Opioid dependence is a chronic, relapsing medical condition that responds best to long-term treatment and support. Services are directed at not only reducing or eliminating the use of illicit drugs and/or the spread of infectious diseases but also at improving the quality of life and functioning of the individuals in the program.

OTPs are shown to improve overall quality of life, reduce the risk of accidental overdose and death, increase employment, increase retention in treatment, identify and treat co-occurring behavioral health conditions, improve pregnancy outcomes for mother and baby, reduce homelessness, and reduce criminal activity.

WHY MEDICATION ASSISTED TREATMENT (MAT)?

MAT is the use of medications combined with counseling and behavioral interventions to provide a holistic approach to the treatment of substance use disorders. Research shows that the combination of medication and behavioral interventions is most successful in the treatment of substance use disorders. MAT is clinically driven with an emphasis on individualized care.

The medications used to assist in recovery and the achievement of treatment goals include Methadone, Buprenorphine (Subutex, Suboxone), and Vivitrol. These medications are approved by the Food and Drug Administration (FDA) for use in the treatment of opioid use disorders.

For more information, or if you are interested in becoming an eligible prescriber, please contact Kurt Snyder, Executive Director, Heartview Foundation, *kurt@heartview.org* or 701.751.5708; or contact Mark Schaefer, Regional Director for Community Medical Services, *Mark.Schaefer@addictiontx.net* or 701.858.1801.

This work is supported from the State Targeted Response Grant from the ND Department of Human Services, Behavioral Health Division.

UND School of Medicine and Health Sciences: Preparing for the Future

News from the Dean of the UND SMHS

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

I was pleased to meet with many of you during the annual meeting of the North Dakota Medical Association held in Grand Forks this past October. During "Breakfast with the Dean," I provided an update on the various programs and efforts of the UND School of Medicine and Health Sciences and answered a variety of questions. For those of you who were unable to attend, I'd like to provide a similar update to you now regarding your School of Medicine and Health Sciences.

Student class size and expansion is now complete.

Student class size expansion afforded under the Healthcare Workforce Initiative (HWI) is now complete—we've added 16 additional medical students/year over the past four years (total 64), and 30 additional health sciences students/year over the past three years (in the fields of physical therapy, occupational therapy, medical laboratory science, athletic training, and physician assistant studies for a total of 90 professionals). In addition, we've added residency training slots in family medicine with a focus on rural practice, general surgery (also with a focus on rural practice), hospitalist medicine, psychiatry (with an emphasis on tele-psychiatry), geriatrics, and a planned orthopedic surgery program scheduled to start this coming summer (funded by Sanford Health but sponsored by the School, similar to the recently inaugurated Sanford-funded, Fargo-based family medicine residency program).

The freshman medical school class of 2021 has been hard at work for the past four months. The class is comprised of 79 students (including seven in our nationally recognized and federally funded Indians into Medicine [INMED] program). The class is split pretty much by gender, reflecting the national trend—47 percent of the class is male, and 53 percent female. The students' average incoming grade point average is an impressive 3.71. We've managed to keep tuition low for all of our students—for medical students, our tuition is the lowest of any regional medical school, and we are at the 16th percentile nationally (meaning that 84 percent of all U.S. schools have tuition rates equal

to or higher than ours). And our medical students' cumulative debt at graduation is below the national average.

All of our eight degree-granting educational programs are nationally accredited, and all for the maximum time period possible, attesting to the confidence that all of the respective national accreditation organizations have in our educational programs. In fact, our physical therapy, medical laboratory science, and histotechnology programs all came through their most recent accreditation evaluation with completely clean evaluations, without a single adverse finding or recommendation!

On the research front, the faculty members at the School continue to grow our research enterprise, studying diseases of importance to North Dakotans (like Alzheimer's and degenerative neurological diseases, cancer, and eating disorders). The School currently has funding for three multi-million dollar collaborative federal grants consisting of two COBREs (Centers of Biomedical Research Excellence) and an INBRE (IDeA [Institutional Development Award] Network of Biomedical Research Excellence). These grants are intended to build the research infrastructure at the School, UND, and throughout North Dakota. One measure of the scope and impact of a research program is the amount of external funding that the program has generated; using a three-year rolling average methodology, sponsored funding at the School has increased about 50 percent (or 7 percent/year) since 2009.

We are working hard to further develop the School's ability to deliver discoveries in the laboratory to the bedside by enabling enhanced clinical and translational research efforts. These efforts are not in isolation; we are coordinating our efforts with partners on the UND main campus, other educational institutions like North Dakota State University, and local partners like Sanford Health.

We are focused on serving the community of North Dakota and fulfilling our purpose.

As a community-based medical school, we are focused on serving the community of North Dakota and fulfilling our purpose as defined in the North Dakota Century Code, which states that: *The primary purpose of the University of North Dakota School of Medicine and Health Sciences is to educate physicians and other health professionals for subsequent service in North Dakota and to enhance the quality of life of its people. Other purposes include the discovery of knowledge that benefits the people of this state and enhances the quality of their lives* (NDCC 15-52-01).

Examples of the many ways in which we do this every day include:

- Recognition by the American Academy of Family Physicians for being among the top schools in the country for the fraction of its graduating class going into family medicine.
- The Indians Into Medicine (INMED) Program is responsible for educating one out of five American Indian physicians in the U.S.
- The Center for Rural Health (CRH) works to strengthen the rural health delivery system through efforts in community health planning, assessment (including data analysis and program evaluation), funding

development, resource development, and local capacity building by working through organizational and system collaboration.

- Partnering with the CRH and the Area Health Education Center (AHEC) to sponsor and participate in a variety of activities that broaden the health care workforce pipeline, including the R-COOL-Health program that incorporates both rural community-based Scrub Camps and the Grand Forks-based Scrub Academy.
- The School continues to emphasize interprofessional education as a key component to improve our health care delivery system. The inclusion of Learning Communities in the new SMHS building further supports and develops this collaborative care model.

The foundation of what we do at the School, though, is based on the efforts of all of you, who give so generously of your time to our students and residents-in-training. As I've mentioned with gratitude before, North Dakota leads the nation in the fraction of physicians in the state who are voluntary clinical faculty members at the School. North Dakota has roughly 1,700 physicians, and more than 1,200 of you are on our voluntary clinical faculty roster. That's more than two out of three! We couldn't exist as a school without you, and all of us (especially our students) are profoundly grateful to you. And if you currently are not a faculty member at UND but are interested in becoming one, please e-mail me (*joshua.wynne@med.und.edu*) and we'll arrange a clinical faculty appointment. I look forward to meeting with you at an upcoming district medical society meeting in your region, and always welcome a call (my office number is 701.777.2514) or an e-mail from you. Thank you again for all that you do.

Make-A-Wish North Dakota: Your Partner in Healthgiving

Jenifer Jones-Dees, MD
Essential Health – Pediatrics

You are our heroes! We could not grant wishes to children with critical illnesses without the partnership of our medical community. Our jobs are not just about diagnosing and treating adults and in my case, children. It is about making a difference in our patients' lives. Because of the care you provide our wish kids and the opportunity you offer them by referring to Make-A-Wish®, you help the family create lasting memories and truly transform lives. That's pretty heroic!

Our heroes are also the children we are privileged to serve through Make-A-Wish. A child with a life-threatening medical condition who has reached the age of 2-1/2 and is younger than 18 at the time of referral is potentially eligible for a wish. Every year, 49 families in North Dakota learn their child is diagnosed with a life-threatening medical condition. Children who may be eligible to receive a wish can be referred by one of four sources:

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

Make-A-Wish does not cold call the families of potentially eligible kids. You play such a vital role to the success of our vision. We ask you to please exercise compassion and suggest to families that they contact us directly with any questions about our program. After a child is referred, Make-A-Wish will work with the treating physician to determine the child's eligibility, i.e. suffering from a progressive, degenerative, or malignant condition currently placing the child's life in jeopardy.

With your solid treatment plan and our wish child answering the question, "If you had one wish what would it be," we partner to give a child hope. There is a big misconception about Make-A-Wish that wishes are reserved only for those who need a "last dying wish." Referring children to Make-A-Wish does not mean that the child is terminally ill. As medicine has evolved, many of our wish kids go on to thrive and live long lives. Some are even wish granting volunteers. Please go to md.wish.org to understand how you can refer a child and to review our Referral Guidance Sheets that describe the medical conditions that typically qualify a child for a wish.

Did You Know?

- 74% of wish parents observed that the wish marked a turning point in their child's response to treatment.
- 89% of health care professionals surveyed say they believe the wish experience can influence wish kids' physical health.
- 81% of parents observed an increased willingness by their wish kids to comply with treatment protocols.

Thank you to all the health care heroes who refer their patients to Make-A-Wish!

We all want improved outcomes for our patients. A wish is more than just a nice thing for a child suffering from a critical illness. Surveys (see insert) and recent studies are showing how wishes can improve a patient's outlook and outcomes; for example, giving him or her an important incentive during treatment – something to look forward to and get stronger for. In fact, my peers and I on the national Make-A-Wish Medical Advisory Council are witnessing improved treatment compliance because of wish experiences as well as positive outcomes in health overall.

As a local chapter board member and medical advisor for Make-A-Wish North Dakota, together, we are dedicated to granting every eligible child's wish. We cannot achieve this vision without heroes like you. Thanks for doing your part in transforming lives, one wish at a time.

MAKE-A-WISH North Dakota

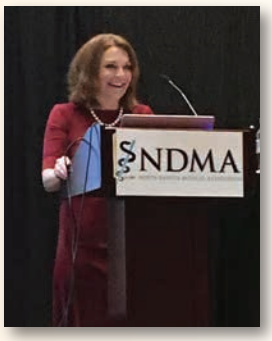
LEARN MORE
Additional information can be found on our website *www.northdakota.wish.org,* requested via email to our Director of Program Services at *klee@northdakota.wish.org* or by calling our office at 701-280-9474.

NDMA 130th Annual Meeting Highlights

The well-attended 130th Annual Meeting of the NDMA House of Delegates was met with remarkable success. The event was held on Friday, October 6 at the Alerus Center in Grand Forks, where new officers were elected and resolutions adopted. Executive director Courtney Koebele provided an overview of the past year's progress, and spoke of current issues that impact physicians and patient care. (See Executive Director Koebele's report: page 5).

In addition to the House of Delegates business, physicians achieving 40 years of service to the medical community were recognized during the awards lunch. The lunch highlights also included many guests that were present to honor the 2017 Friend of Medicine and Physician Community and Professional Service Award recipients.

The meeting provided a wealth of physician and healthcare-related information and education. UND's School of Medicine and Health Sciences (UND SMHS) **Dean Joshua Wynne** presented an update on the School of Medicine; **Dr. Bruce Scott**, vice-speaker of the American Medical Association (AMA) Advocacy Group provided an update on policy issues impacting the field of medicine; **Dr. Paul Carson**, an infectious disease specialist in Fargo, discussed the burden of antibiotic overuse; and a presentation by **Alison Traynor** and **Kora Dockter** shared research findings in suicide and evidence-based practices to save cost and patients' lives.



NDMA PAC Social

The meeting kicked off with a Thursday night NDMA PAC social at Rhombus Guys Pizza in downtown Grand Forks and was well attended by members across the state. This fundraiser is an important function for NDMA as the money generated helps NDMA to become active legislatively on issues that impact physician practices and patient healthcare.

House of Delegates Highlights

Joshua C. Ranum, MD, NDMA Speaker of the House, convened the House of Delegates. The delegates adopted four resolutions and updated NDMA's mission statement:

RESOLUTIONS

1. ***Opioid Crisis:*** NDMA will continue to support the PDMP and encourage members to follow the Board of Medicine rules; continue to work with statewide stakeholders to identify and remove existing barriers for patients seeking treatment; and work with its members to enhance and provide education on prescribing and treatment.

2. ***Sports Team Physician Licensure:*** NDMA will advocate for a change in North Dakota Century Code, which will allow an athletic team physician licensed in another state to be exempt from North Dakota licensure.

3. ***Physician Assisted Suicide:*** NDMA formally adopts the position against physician-assisted suicide and euthanasia in that they are fundamentally incompatible with the physician's role as healer.

4. ***USMLE – Step 2***: Transfer of Jurisdiction over Required Clinical Skills Examinations to U.S. Medical Schools: NDMA will advocate for the North Dakota Board of Medicine to eliminate the U.S. Medical Licensing Examination Step 2 Clinical Skills examination as a state licensure requirement.

MISSION STATEMENT

The mission statement was amended to better reflect the purpose and activities of NDMA. Following is the revised, and approved mission statement:

The mission of the North Dakota Medical Association is to advocate for North Dakota's physicians, to advance the health, and promote the well-being of the people of North Dakota.

ELECTION OF OFFICERS

Election of NDMA officers was held during the Annual Meeting: Pictured above from left to right: President: Dr. Fadel Nammour (Fargo); Past-President: Dr. Debra Geier (Jamestown); Secretary/Treasurer: Dr. Joshua C. Ranum (Hettinger); Vice-President: Dr. Misty K. Anderson (Valley City); Speaker of the House: Dr. Stephanie K. Dahl (Fargo). Not pictured are AMA Delegate Dr. Shari L. Orser (Bismarck) and AMA Alternate Delegate Dr. A. Michael Booth (Bismarck).

MEMORIAL OBSERVATION

During the House of Delegates meeting, a moment of silence was observed to remember our North Dakota physician colleagues who have passed away since our last meeting.

Richard Arazi, MD
Paul H. Freiberg, MD
Walter A. Gokavi, MD
Mansureh S. Iravani, MD DMD
Robert P. Jordheim, MD
Curtis A. Juhala, MD
Joseph W. Miller, MD
Margaret E. Morgan, MD
Riffat F. Morgan, MD
Joshua O. Omotunde, MD

40 Years of Service Certificates of Appreciation

At the awards lunch, the NDMA tradition was observed of honoring physicians who have achieved at least 40-years of service to the medical community upon graduation from medical school. This year's honorees are sixteen physicians from the graduating class of 1977:

- A. Michael Booth, MD, Bismarck
- Brad R. Buell, MD, Fargo
- David J. Clardy, MD, Fargo
- Rick J. Geier, MD, Carrington
- Ernest N. Godfread, MD, Bismarck
- Ronald D. Isackson, MD, Dickinson
- Joel L. Johnson, MD, Grand Forks
- Samy S. Karaz, MD, Fargo
- Keith G. Lesteberg, MD, Fargo
- Donald J. Matthees, MD, Fargo
- Shari L. Orser, MD, Bismarck
- Jitendra R. Parikh, MD, Grand Forks
- Hong Q. Peng, MD, Fargo
- Gerald S. Smyser, MD, Victoria, MN
- Randolph E. Szlabick, MD, Grand Forks
- Harjinder K. Virdee, MD, Fargo

Shari L. Order, MD, was present to accept her certificate.

SUPPORT THE NDMA PAC

The North Dakota Medical Association advocates for physicians on crucial issues that impact patient safety, protecting the patient-physician relationship, reimbursement and the ever-changing landscape of implementing health care reform.

YOUR DONATION WILL KEEP NDMA ADVOCATING FOR YOU!

Please support your NDMA PAC with a financial gift today! To donate, contact NDMA at 701-223-9475.

2017 NDMA Awards

Each year NDMA honors a physician and a non-physician who have made outstanding contributions to the North Dakota medical profession, their patients and community. Many friends, family members and community leaders attended the event to help honor these distinguished award recipients.

Dr. Kim Krohn: Physician Community and Professional Service Award

The North Dakota Medical Association presented Dr. Kim Krohn with a Physician Community and Professional Services Award.

Since 1977, NDMA has been honoring physicians with this prestigious award that recognizes physicians for outstanding leadership and service to the people of North Dakota and to the profession of medicine.

Dr. Krohn was nominated for this award by Dr. James Brosseau of Grand Forks. According to Dr. Brosseau, Krohn is a modest and compassionate physician who is a role model for every medical practitioner.

Dr. Krohn has devoted her entire professional career in Minot and has provided exemplary service in primary care. She served with distinction as Program Director of the UND School of Medicine and Health Sciences Center for Family Medicine of Minot's Family Medicine Residency Program. As program director, she brought the program to new heights by developing a rural track residency program from the ground up. She served on numerous UND faculty committees including residency review committees, administrative faculty selection committees and faculty review committees. In addition, she presented at numerous regional, national and international events to teach procedures in family medicine.

Her endless contributions to the Minot community expanded into her service as Deputy Ward County Coroner and Forensic Medical Examiner for the Northern Plains Children's Advocacy Center.

Through her service at Trinity Hospital, she served in many roles: Medical Executive Committee Member, Vice-Chief of Medicine Department, Vice-Chair of Quality Committee, Chair of the Education Committee; and a member of the Medical Information Technology Committee.

Dr. James Brosseau presents the Physician Community and Professional Service Award to Dr. Kim Krohn.

Dr. Joshua Wynne presents the Friend of Medicine Award to Randy Eken.

Although Dr. Krohn's service was based in Minot, her outstanding work expanded to statewide organizations by serving as president of ND Medical Association; president of ND Academy of Family Physicians Foundation; and president of ND Society of Obstetrics and Gynecology.

Randy Eken: NDMA Friend of Medicine Award

The North Dakota Medical Association presented Randy Eken with a Friend of Medicine Award.

This is the eighteenth year NDMA presented this prestigious award to a non-physician dedicated to the field of health. The award acknowledges people who have distinguished themselves in North Dakota by serving as effective advocates for health care, patient services, or the medical profession.

Eken was nominated by Dr. Joshua Wynne, UND's vice president for health affairs and dean of the School of Medicine and Health Sciences. Eken served the UND School of Medicine since 1983, and prior to his retirement this past June, was the UND Associate Dean for Administration and Finance. His responsibilities included financial oversight and planning for thirteen major capital projects. He is known for his tireless dedication to the school and for ensuring students can fulfill their career goals.

His dedication to the profession of medicine is known by all who are associated with the UND School of Medicine. He coined the name for the "healthcare workforce initiative" or HWI, which has been instrumental in developing the future of physicians and healthcare in the state.

North Dakota Medical Association Awards

The North Dakota Medical Association is proud to sponsor awards for outstanding medical students who exemplify high scholarship, integrity, leadership and initiative.

Congratulations to the UND School of Medicine Award Winners!

2017 Sophomore Outstanding Award Winners

Second-year student North Dakota Medical Association award winners are nominated by their peers from the Class of 2019. The awards recognize three students for outstanding performance in the following three curricular areas:

Group Leadership and Professionalism

Sean Henley, Casper, Wyoming

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.

Peer Teaching

Shauna Newton, Billings, Montana

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.

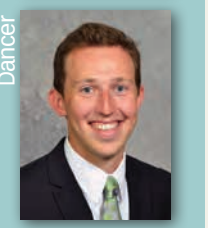
Integration of Basic Science and Clinical Application

Michael Dancer, Fargo, North Dakota

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

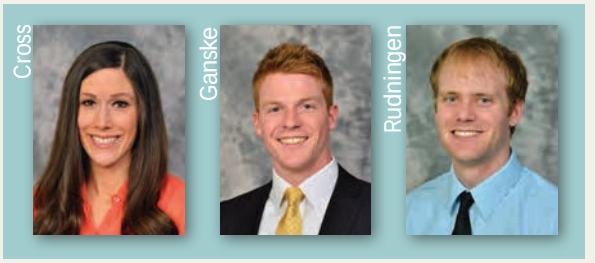

Henley


Newton


Dancer

2017 Senior Doctor of Medicine Outstanding Award Winners

North Dakota Medical Association Awards were given to three outstanding class of 2017 senior medical students. The awards exemplify outstanding leadership, high scholarship, integrity and initiative.


Cross

Ganske

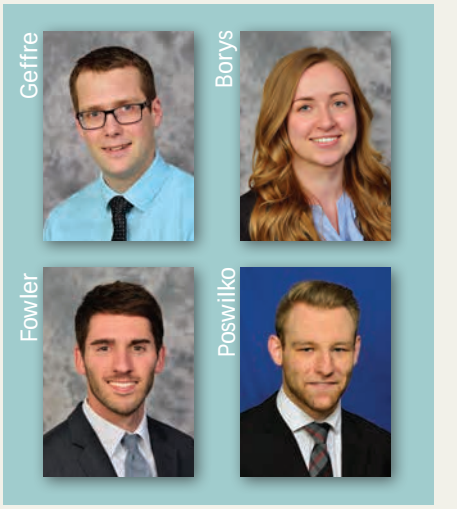
Rudningen

- *Cassandra P. Cross*, Oregon City, Oregon
- *Alec E. Ganske*, Mankato, Minnesota
- *Kyle E. Rudningen*, Clearwater, Minnesota

2017 North Dakota District Medical Society Awards

The North Dakota District Medical Society Awards are given by the society on each campus to a class of 2017 senior medical student, who best exemplifies high scholarship, characteristics of integrity, leadership, and initiative.

- First District, Fargo: *Marcus J. Geffre*, Mayville, North Dakota
- Third District, Grand Forks: *Amy R. Borys*, Cando, North Dakota
- Fourth District, Minot: *Zachary G. Fowler*, Minot, North Dakota
- Sixth District, Bismarck: *Scott M. Poswilko*, Dickinson, North Dakota


Geffre

Borys

Fowler

Poswilko

Renew Your NDMA Membership with North Dakota's Largest Physician Organization

Physicians reap many benefits from our member organization, including:

- The personal and professional satisfaction of being a strong voice for the practice of medicine and for improving the health of North Dakotans
- An inside perspective on developing legislation
- Opportunities to help shape health care policy at the state and national level and serve on public and private boards or committees
- Networking with local colleagues and physicians across the state and beyond our borders
- Enhancing leadership skills by serving in NDMA leadership positions
- Easy access to a broad range of CME credits

Renewing your NDMA membership ensures that your voice will be heard.

For more information contact us at 701-223-9475 or email staff@ndmed.com

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

1622 East Interstate Avenue
Bismarck, North Dakota 58503

The mission of the North Dakota Medical Association is to advocate for North Dakota's physicians, to advance the health, and promote the well-being of the people of North Dakota.

Family Doctors Spend 86 Minutes of "Pajama Time" with EHRs Nightly

Sara Berg
AMA Senior Staff Writer

A new study using electronic health record (EHR) system event-logging data to track family physicians' workdays finds that primary care physicians spend more than half of their work day interacting with the EHR—with nearly a quarter of that computer work happening after clinic hours. Yet, physician experts argue, a big chunk of the administrative work family physicians and other doctors do on EHRs could be properly delegated to other members of the practice team.

The study, published in *Annals of Family Medicine*, was co-written by researchers from the AMA and the University of Wisconsin's medical school and engineering department. Over a three-year period, all Epic Systems Corp. EHR interactions from 142 family physicians in a Wisconsin single health care system were captured from "event logging" records used to monitor system performance.

The tale of all that tape is that each weekday, physicians spent an average of 5.9 hours out of an 11.4-hour workday working in the EHR. That consisted of 4.5 hours during clinic times and 1.4 hours after work. Clerical and administrative tasks such as documentation, order entry, billing and coding and system security, accounted for 44 percent of the total EHR usage time. About one-third of the time was spent on medical care EHR tasks such as chart reviews and problem lists, while inbox management took up 24 percent of family physicians' time.

Work previously done by other team members has been shifted to the physician.

One of the study's co-authors, Christine Sinsky, MD, is a practicing internist and has used an EHR for more than 15 years. In that time, she said, increasing requirements and regulations have fundamentally changed the nature of a physician's work.

"Work previously done by other team members has been shifted to the physician in the EHR," said Dr. Sinsky, who is the vice president of professional satisfaction at the AMA and practices at the Medical Associates Clinic and Health Plans in Dubuque, Iowa.

"Tasks that may have earlier required a matter of seconds, now may each take one to two minutes. Add this up over the thousands of individual tasks each day and it wasn't surprising that I and other physicians began to wonder if we were spending more time caring for the computer than caring for the patient," she told *AMA Wire®*.

Especially concerning, Dr. Sinsky said, is the 86 minutes family physicians spend doing administrative work after hours or at home, which she has dubbed "pajama time" with the EHR.

Event logs are available to help identify areas of EHR work that can be delegated to help reduce workload and improve professional satisfaction. There are more than 1,000 event descriptions to identify user interactions with Epic, which includes both patient care-related events and system-level technical events.

The data from the Wisconsin family physicians' event logs buttress the findings in a direct-time motion observation study that Dr. Sinsky and colleagues published in 2016 in *Annals of Internal Medicine*, which found that for each two hours physicians spend on direct patient care, they spend one hour wrestling with EHR tasks.

Dr. Sinsky explained that most organizations have access to the type of back-end data examined for this new study, and that the information can help determine how much after-hours time their own physicians are spending in the EHR rather than with their families, friends or getting much needed rest.

"Individual organizations can also use this audit data to understand how much of the patient visit is spent on the computer and how much of the total physician workday is spent on clerical tasks—such as order entry and visit note documentation—that do not require the skills and training of a physician," said Dr. Sinsky.

Developing organizational metrics can help cut stress and burnout related to EHR systems. There are five potential solutions to common problems exhibited in primary care to help physicians find "joy in practice," the study's authors wrote.

According to the study, these proposed solutions are:

- Proactive planned care.
- Team-based care that includes expanded rooming protocols, standing orders and panel management.
- Sharing of clerical tasks including documentation, order entry and prescription management.
- Verbal communication and shared inbox work.
- Improved team function.

Especially concerning is the 86 minutes family physicians spend doing administrative work after hours or at home.

"The most powerful intervention to increase direct clinical face time with patients is advanced team-based care where the physician is paired with a stable team of two or three clinical assistants," said Dr. Sinsky. "In this model, one of the clinical assistants provides in-room support during the patient visit, performing real-time information retrieval, visit note documentation and pending of orders."

"Together, this care team is able to efficiently provide access and care to patients who need to be seen, close preventive and chronic-illness care gaps in a standardized manner and–because the medical assistant or nurse was in the room during the appointment–can also provide more robust between visit care," she added.

By recognizing the key challenges physicians face when implementing health IT and the increase of direct-to-consumer digital health apps, the AMA aims to help physicians navigate and maximize technology for improved patient care and professional satisfaction.

The AMA is focused on influencing health IT with the goal of enhancing patient-centered care, improving health outcomes and accelerating progress in health care.

Sources

http://www.annfammed.org/content/15/5/419.full: Tethered to the EHR: Primary Care Physician Workload Assessment Using EHR Event Log Data and Time-Motion Observations; *http://annals.org/aim/article-abstract/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties*: Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties

NDMA Strategic Planning

The North Dakota Medical Association (NDMA) council determined that a strategic planning process would be a beneficial process to our membership organization. The process helps identify strategies so that our organization and members can be successful in achieving its mission, goals and objectives.

To help make the process more effective, NDMA contracted with JM Strategies LLC in late 2016 to facilitate and manage its strategic planning process. NDMA leadership and the consultant determined early on that feedback from NDMA's membership, as well as input from the non-member physician community, was necessary to develop a comprehensive plan. Accordingly, the planning process was conducted in three phases.

The first and second phases focused on gathering research. Separate online surveys were distributed to NDMA members and non-members. The information from the survey provided direction for the second phase, which involved a focus group consisting of NDMA members and physician non-members. Results of the combined phases were presented to the planning committee in preparation for the third phase, where plan goals, objectives and implementation decisions were made.

To complete the third phase, a strategic planning meeting was held in Bismarck on June 24, 2017. In attendance were President Debra Geier, Vice President Fadel Nammour, Past-President Steve Strinden, 6th District Councilor Todd Schaefer, Ethics Commission Chair Kristina Schlecht, Speaker of the House Josh Ranum, Secretary Treasurer Misty Anderson, 1st District Councilor Stephanie Dahl, and 9th District Councilor Dennis Wolf. NDMA staff Courtney Koebele and Leann Benson were also in attendance.

The following three primary goals were identified:

1) Communications: Improve NDMA's communications with members, non-members, policy-makers, and the general public;
2) Membership: Increase NDMA membership and improve member engagement;
3) Governance: Evaluate NDMA's governance structure to identify areas for modernization, greater organizational efficiencies, and improved participation.

The NDMA Council retains ultimate responsibility for the implementation of this strategic plan. In the interest of ensuring an effective and efficient implementation process, a task force consisting of 12 NDMA Council members was established and charged with directing the implementation process.

The task force was organized into three subcommittees each consisting of four members and charged with managing one specific goal (communications, membership, and governance). These subcommittees will report to the task force, which will report to the NDMA Council. The Council and the task force will determine best strategies and practices for plan implementation and establish benchmarks to measure progress and success.

The subcommittees are: Communications: Misty Anderson, Kim Krohn, Todd Schaffer and Mike Booth; Membership subcommittee: Parag Kumar, Fadel Nammour, Josh Ranum and Dennis Wolf; Governance subcommittee: Stephanie Dahl, Debra Geier, Shiraz Hyder and Steve Strinden.

Through this process, NDMA looks forward to improvements that lead to continued growth in an ever-changing environment.

Rethinking Pain Management

Toward increased patient safety with opioid prescriptions

Treating patients with chronic pain is complex and challenging. Many clinicians express concern about how to safely manage the needs of an increasing number of pain patients in an environment of federal and state initiatives aimed at reducing opioid prescriptions.

MMIC, UMIA and Arkansas Mutual have responded to policyholder concerns with an education program, "Rethinking Pain Management for Community Health and Safety." This one-hour in-person education program uses findings from an analysis of malpractice claims and identifies strategies and training to empower clinicians and team members to support this complex issue while managing the emerging risks. The following is a high-level overview of the program and recommended risk mitigation strategies.

Scope of the opioid problem

The Centers for Disease Control and Prevention (CDC) notes that over the past 25 years there has been a dramatic increase in the use of prescription opioids for the treatment of chronic, non-cancer pain. The CDC estimates that 20 percent of patients presenting to physician offices with pain receive an opioid prescription.[1] At the same time, the increasing use of opioids for the treatment of chronic pain has resulted in unintended consequences. The CDC has declared that our nation is in the midst of an unprecedented opioid epidemic, with more than 33,000 people killed by opioids (including prescription opioids and heroin) in 2015. Nearly half of all opioid overdose deaths involve a prescription opioid.[1]

In a 2016 study, 91 percent of patients who survived an opioid overdose received more opioid prescriptions upon discharge. The researchers identified this as a missed opportunity to diagnose and treat substance abuse.[2] In another study of more than 35,000 hospitalizations for opioid abuse and overdose, only 16.7 percent of patients received medication-assisted treatment (MAT) for substance abuse in the 30 days following discharge.[3]

In 2015, more than 33,000 people were killed by prescription opioids and heroin.

Opioid use disorder (OUD) is a substance use disorder identified and described in the DSM-5. OUD and opioid addiction are two terms that are often used interchangeably to describe a chronic, relapsing disease, not a lifestyle choice—one of the common myths surrounding addiction.

Lori Atkinson, RN, BSN, CPHRM, CPPS
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Every community is different in terms of patients, clinicians, prescription opioid use and OUD. According to the CDC, "Prescribing rates for opioids vary widely across different states and regions with clinicians in the highest-prescribing state writing almost three times as many opioid prescriptions per person in 2012 as those in the lowest prescribing states.[4]" In 2016, the CDC released the "CDC Guideline for Prescribing Opioids for Chronic Pain" aimed at changing these unsafe prescribing patterns to ensure the safest and most effective chronic pain treatment.

Risks to patients and health care providers

Treating chronic pain with prescription opioids involves risks for patients, clinicians and health care organizations, including:

- Adverse outcomes, including addiction, overdose and death
- Licensing actions for improper prescribing
- Drug diversion on the part of the patient or health care professional. Drug diversion is the transfer of any legally prescribed controlled substance from the individual for whom it was prescribed to

another person for illicit use.
- DEA criminal prosecution for prescribing without a legitimate medical purpose
- Medication-related malpractice claims

Licensing actions

Rules and regulations relating to pain management are found in nearly every state outlining clinician education requirements, treatment plans, informed consent, patient examination and screening for substance abuse, patient referral to specialists, limitations on prescribing schedule II and III controlled substances, and regulation of pain clinics and treatment programs.[5] Many states also require clinicians to access their state's prescription drug monitoring program to determine whether a patient is receiving prescription controlled substances from other clinicians.[6]

When clinicians and licensed health care professionals don't follow these rules and regulations, state licensing boards can take actions that may include public warnings, fines, practice restrictions, remedial education, probation, and suspension or revocation of license.

Medication-related malpractice claims

An analysis of MMIC medication-related malpractice claims involving chronic pain and opioids revealed that the

Reducing risk, increasing safety

These three strategies can help reduce risks inherent in prescription opioid use and enhance patient safety.

1. Incorporate evidence-based guidelines into practice.

Federal, state and specialty-based clinical treatment guidelines can be used as resources to develop chronic pain management policies to ensure consistent evidence-based practice. Most of these clinical guidelines are voluntary and based on emerging evidence, so when writing policies, be sure to allow for patient-specific treatment plans based on the patient's condition, risks and unique needs. State require-ments such as prescribing and refill limits should be incorporated as well, so policies need frequent review and updates.

2. Implement reliable patient management processes to assess, monitor and communicate.

- **Assess.** Standard tools and algorithms (e.g., PEG, ORT, ICSI Pain Assessment Algorithm) should be used to assess and document a patient's pain intensity, functional status, quality-of-life impact, opioid addiction risk, behavioral health co-morbidities and aberrant drug-related behaviors (e.g., early refill requests, falsification of a prescription, illegal drug use) to ensure consistent care across your organization.
- **Monitor.** Patient monitoring systems that include patient dashboards, state prescription drug monitoring programs, and urine drug tests are a data-driven approach to evaluating the treatment plan and the progress toward patient goals.
- **Communicate.** Motivational interviewing and shared decision-making[7] are patient-centered ways to facilitate communication. When assessments reveal that opioids are doing more harm than good, a respectful conversation with the patient is in order. Clinicians need to use empathetic communication skills to discuss the behaviors revealed on the assessments and engage patients in revisiting the treatment plan.

3. Provide training, tools and education.

Research indicates that although clinicians are in need of additional training on pain management and prescription opioids, the majority are in support of clinical and regulatory strategies to reduce the harm caused by opioids.[8] Education and training should focus on:

- Acute and chronic pain pathophysiology
- Pain treatment modalities including non-opioids, opioids and non-pharmacologic treatments
- Pain and function assessment tools; risk stratification tools
- Evidence-based guidelines and policies
- Monitoring for adverse effects and aberrant behavior
- Opioid use disorder and medication-assisted treatment (MAT)
- Empathetic communication skills

contributing factors in the outpatient setting were often related to selection and management of therapy. The claims involved patients with high numbers of refills combined with a lack of pain and function assessments, unsafe drug combinations, inadequate assessment for comorbidities, lack of opioid risk stratification and undiagnosed opioid use disorder.

In the outpatient setting, patient noncompliance and ineffective communication regarding the risks of opioids were also factors, while diversion by health care professionals and a lack of policy and procedures contributed to the allegations in the inpatient setting.

Organizations should begin immediately to assess their prescribing practices and policies and implement strategies to protect their communities and stem the tide of the growing opioid epidemic.

References
1. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain – United States. MMWR 2016;65:1–49.
2. Larochelle MR, Liebschutz JM, Zhang F, Ross-Degnan D, Wharam JF. Opioid prescribing after nonfatal overdose and association with repeated overdose: a cohort study. Ann Intern Med. 2016;164:1-9.
3. Naeger S, Ali MM, Mutter R, Mark T, Hughey L. Prescriptions filled following an opioid-related hospitalization. Psychiatr Serv. 2016;67(11):1262-1264.
4. Centers for Disease Control and Prevention. Vital signs: variation among states in prescribing of opioid pain relievers and benzodiazepines – United States, 2012. MMWR 2014; 63(26):563-568.
5. National Alliance for Model State Drug Laws. Overview of State Pain Management and Prescribing Policies. http://www.namsdl.org/library/74A8658B-E297-9B03-E9AE6218FA0F05B0/. Published 2016. Accessed March 16, 2017.
6. National Alliance for Model State Drug Laws. Mandated Use of State Prescription Drug Monitoring Programs. https://tinyurl.com/k4akcwd. Published 2016. Ac-cessed March 16, 2017.
7. Elwyn G, Dehlendorf C, Epstein RM, Marrin K, White J, Frosch DL. Shared decision making and motivational interviewing: achieving patient-centered care across the spectrum of health care problems. Ann Fam Med. 2014;12(3):270-275.
8. Hwang CS, Turner LW, Kruszewski SP, Kolodny A, Alexander GC. Primary care physicians' knowledge and attitudes regarding prescription opioid abuse and diver-sion. Clin J Pain. 2016;32(4):279-84.

2018 Events Calendar

January 15-19, 2018
ND Academy of Family Physicians
Annual Big Sky Conference
Big Sky, MT

February 10, 2018
ND Society of Orthopaedic
Surgeons Annual Meeting
Alerus Center, Grand Forks

April 13-14, 2018
ND-SD ACS Annual Meeting
The Lodge, Deadwood, SD

April 28, 2018
ND Society of Anesthesiologists
UND School of Medicine
Grand Forks, ND

May 14, 2018
UND SMHS Graduation
Grand Forks, ND

August 17-18, 2018
ND Society of Obstetrics and
Gynecology
Community Center – Medora, ND

October 4-5, 2018
North Dakota Medical Association
Annual Meeting
Bismarck, ND

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

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