North Dakota Medical Association

Delegate Handbook

Table of Contents

Chapter 1 – Order of Business

NDMA 2014 House of Delegates Order of Business 1-1
House of Delegate Reports & Resolutions-List of Policy Items for Calendar 1-3
Rules of Business 1-4
Policy Development 1-5
NDMA 2014 Officers and Councillors 1-6
NDMA 2014 Members of the House of Delegates 1-7
Substantive Policies (2000-2014) 1-9

Chapter 2 – Officer Reports

Report of the President 2-1
Report of the Vice President and Council Chair 2-3
Report of the Secretary-Treasurer
- 2013 NDMA Membership by Member Type 2-13
- 2013 NDMA Regular Active Membership by District 2-13
- NDMA Regular Active Members 1994-2013 Comparison 2-14
- NDMA Membership 2012-2013 Comparison 2-14
- 2012-2013 AMA Membership Comparison Report 2-14
- New 2013 Regular Active Members 2-15
- In Memoriam 2-16
- Presidents of the North Dakota Medical Association 2-17
- NDMA Physician Community and Professional Services Award Recipients 2-18
- NDMA Friend of Medicine Award Recipients 2-19
- 2014 Recipients of Forty Year Certificate of Appreciation 2-19
- Balance Sheet as of December 31, 2013 2-20
- 2013 Profit and Loss Budget vs. Actual 2-21
- NDMA 2014 Approved Budget 2-22
- North Dakota Medical Research Foundation Report 2-23

Report of the AMA Delegate 2-24
Report of the Executive Director 2-27

Chapter 3 – Council

Council Minutes October 3-4, 2013 3-1
Council Minutes December 10, 2013 3-4
Council Minutes January 14, 2014 3-6
Council Minutes March 1, 2014 3-7
Council Minutes May 27, 2014 3-8

Chapter 4 – District Reports
Officers of the NDMA District Medical Societies 4-1
District Reports 4-2

Chapter 5 – Commission Reports
Report of the Commission on Ethics 5-1
Report of the Commission on Legislation and Governmental Relations 5-2
Report of the Commission on Medical Services and Public Relations 5-5
Report of the Commission on Socio-Economics 5-6

Chapter 6 – Organization Reports
Report of North Dakota Health Care Review, Inc 6-1
Report of the Blue Cross Blue Shield Board of Directors 6-2
Report of the Midwest Medical Insurance Company Board of Directors 6-4
Report of the North Dakota Health Information Technology Advisory Committee 6-8
Report of the North Dakota Medicaid Drug Utilization Review Board 6-9
Report of the North Dakota Medicare Carrier Advisory Committee 6-11
Report of the North Dakota Prescription Drug Monitoring Program Advisory Committee. 6-12
Report of the North Dakota State Board of Medical Examiners 6-13
Report of the North Dakota State Health Officer 6-15
Report of the North Dakota State Trauma Committee 6-17
Report of the North Dakota Tobacco Prevention and Control Advisory Committee 6-18
Report of the University of North Dakota School of Medicine and Health Sciences 6-20

Chapter 7 – Resolutions
Resolution No. 1 7-1
Resolution No. 2 7-2
Resolution No. 3 7-3
Resolution No. 4 7-4
Resolution No. 5 7-5
Resolution No. 6 7-6
Resolution No. 7 7-8

Chapter 8 – Constitution and By-Laws
North Dakota Medical Association Constitution 8-1
North Dakota Medical Association By-Laws 8-3

NDMA
Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

PO Box 1198
1622 East Interstate Avenue
Bismarck, North Dakota
58502-1198

701.223.9475
Fax 701.223.9476
www.ndmed.org

Foreword

Dear NDMA Member:

I welcome you to the 127th Annual Meeting of the NDMA House of Delegates. Your participation is *critical* to our efforts in crafting a policy agenda on behalf of all North Dakota physicians and their patients, particularly today in this unprecedented environment of transformation in the national health care delivery system.

The reports and resolutions in this Delegate Handbook provide the basis for our business meeting, which is held in two separate sessions. **The First Session of the House of Delegates is on Friday, October 3, starting at 9:00 a.m. The Second Session will convene at 2:00 p.m. on Friday, October 3.** Elections will also be held for NDMA President, Vice President, Secretary-Treasurer, and Speaker of the House, AMA Delegate, and AMA Alternate Delegate.

Note particularly the summary list of policy items for the calendar on page 1-3 of the Delegate Handbook. Remember, additional resolutions may be offered from the floor during our First Session.

There are a number of activities during the annual meeting. Friday begins with our annual breakfast at 7:30 a.m. with **UND SMHS Dean Joshua Wynne.** At 8:30 a.m. **Dr. Maya Babu**, AMA Board of Trustees, will provide us with an *AMA Update* followed by the first session of the House of Delegates at 9:00 a.m.

The education program begins at 10:30 a.m. with the presentation: *Dispelling the Myth: Cyber Risk is not a Technology Problem* by **Trish Lugtu** of Midwest Medical Insurance Company (MMIC) and a second presentation also by **Trish Lugtu:** *Managing Physician Reputations: When Your Online Reputation is On the Line* will begin at 11:30 a.m. Lunch will begin at 12:30 with our luncheon speaker **UND President Robert Kelley**.

Thank you for joining us for the 127th Annual Meeting of the NDMA House of Delegates!

Misty Anderson, DO
Speaker of the House

President
Steven P. Strinden, MD
Fargo

Vice President
Debra A. Geier, MD
Jamestown

Secretary-Treasurer
Fadel E. Nammour, MD
Fargo

Speaker of the House
Misty K. Anderson, DO
Valley City

Immediate Past President
A. Michael Booth, MD
Bismarck

AMA Delegate
Robert W. Beattie, MD
Grand Forks

AMA Alternate Delegate
Shari L. Orser, MD
Bismarck

AMA-RFS Delegate • AMA-RFS Sectional Delegate
Paul Bahal, MD
Minot

Executive Director
Courtney Koebele, JD

Chief Operating Officer
Leann Benson

Communications Director
Katie Fitzsimmons

Administrative Assistant
Annette Weigel

2014 NDMA House of Delegates

Hilton Garden Inn • Grand Forks, ND

Order of Business

Please refer to your meeting agenda for a complete listing of all educational and special events.

Friday, October 3, 2014 – James F. Buchli Room

8:30 a.m. **AMA Update** – Maya Babu, MD, MBA, AMA Board of Trustees

9:00 a.m. **House of Delegates – First Session**

1. Call to Order – Misty K. Anderson, DO, Speaker of the House
2. Roll Call – Fadel E. Nammour, MD, Secretary-Treasurer
3. Welcome and Remarks of the President – Steven P. Strinden, MD
4. Remarks of the Executive Director – Courtney Koebele
5. Report of Nominations Committee for NDMA Offices
   - President: Steven P. Strinden, MD, Fargo
   - Vice-President: Debra A. Geier, MD, Jamestown
   - Secretary/Treasurer: Fadel E. Nammour, MD, Fargo
   - Speaker of the House: Misty K. Anderson, DO, Valley City
   - AMA Delegate Robert W. Beattie, MD, Grand Forks
   - AMA Alternate Delegate Shari L. Orser, MD, Bismarck
6. Election of Officers (for positions with only one nomination)
7. Additional Remarks from any NDMA Officers or Commission Chairs
8. Consideration of the Calendar
   - Review of Handbook Reports and Resolutions – Council Referrals
   - Call for Additional Resolutions / Appointment of Reference Committee
9. Announcements and Schedule Reminders
10. Open Testimony on Handbook Reports and Resolutions before the Reference Committee (The Reference Committee will later meet in executive session for consideration of testimony and determination of recommendations to the House.)

<u>Friday, October 3, 2014</u> – James F. Buchli Room

2:00 p.m. **House of Delegates – Final Session**

1. Call to Order – Misty K. Anderson, DO, Speaker of the House

11. Roll Call – Fadel E. Nammour, MD, Secretary-Treasurer

2. Election of Officers (if necessary)

3. President's Address

4. Any Additional Remarks

5. Report of the Reference Committee of the Whole

6. Consideration and Action on Reference Committee Recommendations

7. Other Business

8. Announcements and Adjournment

House of Delegate Reports and Resolutions
List of Policy Items for Calendar

Reports

Consider for acceptance: Report of the Vice President (Council Chair), Debra A. Geier MD (p. 2-3)

Consider for acceptance: Report of the Chair of the Commission on Legislation, (Preliminary 2015 Legislative Agenda), Sarah L. Schatz, MD (p. 5-2)

Other Reports

Consider for acceptance: Reports of the President, Secretary-Treasurer, Executive Director, (See Reports in Chapter 2), Chairs of the Commission on Ethics, Commission on Medical Services and Public Relations, and Commission on Socio Economics. (See Reports in Chapter 5).

Resolutions

Res. 1 (NDMA Council) – Interstate Licensure Compact – A resolution urging the North Dakota Board of Medical Examiners to consider and propose adoption of the Interstate Medical Licensure Compact in the 2015 North Dakota Legislative Session.

Res. 2 (ND Chapter of the American College of Emergency Physicians) – Assault Against a Health Care Provider – A resolution urging the NDMA seek legislation that provides for a class C felony classification when a health care provider is assaulted.

Res. 3 (NDMA Council) – Safe Injection Practices- A resolution urging healthcare practitioner licensing boards to require safe injection practices training.

Res. 4 (Commission on Ethics) – Disrespect and Derogatory Conduct in the Patient-Physician Relationship – A resolution urging health care organizations to develop best practices for attending to abusive patients and encourage development of guidelines for health care providers to follow in non-life threatening situations when they encounter patients who verbally abuse or threaten physical abuse.

Res. 5 (NDMA Council) – Behavioral Health – A resolution urging NDMA to advocate in the 2015 legislative session to significantly increase funding to the ND Department of Human Services so as to increase and improve the delivery of mental health services throughout our state.

Res. 6 (NDMA Delegate to the AMA) – Support of Iowa Medical Society Resolution to the AMA House of Delegates on Access and Equity in Telemedicine – A resolution urging NDMA support the Iowa Medical Society resolution that the AMA will establish as policy that there should be no geographic adjustment in payments for telemedicine, and lobby Congress to require the Centers for Medicare & Medicaid Services (CMS) to: 1) pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined "shortage" areas, if that area can show a shortage of those physician specialists; and 2) eliminate geographic adjustments for telemedicine payment to providers.

Res. 7 (NDMA Delegate to the AMA) – Support of Iowa Medical Society Resolution of the AMA House of Delegates on Price Transparency – A resolution urging the NDMA support the Iowa Medical Society resolution that our AMA will: 1) develop an educational program by early 2015 for physicians that would make healthcare price and reimbursement site differences clear; and 2) work with the Center for Healthcare Transparency (CHT), the Health Care Cost Institute (HCCI), and the Centers for Medicare & Medicaid Services (CMS) to make their websites easier to access and use, and make their data for hospital and physician prices and payments more accurate and useful for physicians, purchasers, and patients.

Rules of Business

I. The Object of Parliamentary Procedure

The object of parliamentary procedure is to provide a guide for conducting business meetings. It provides a set of rules and principles for an orderly method of conducting these meetings and for the oral debate of controversial matters. It is the means by which the will of the majority can be determined in an orderly manner. Robert's Rules of Order, Revised, governs the proceedings of the NDMA House of Delegates.

Parliamentary procedure provides for free and open debate which should assure a fair hearing for all. Its basic principles are flexible enough to serve the needs of every type of meeting, and it can be used with varying degrees of formality.

II. Duties and Rights of Members of an Assembly

A. The Primary Duties. A Delegate member should:
1. Properly obtain the floor before speaking;
2. Avoid speaking upon any matter until it has been properly brought before the assembly;
3. Never interrupt another member unless the motion which he is about to make permits it;
4. Refrain from all personalities in debate;
5. Abide by the spirit as well as by the letter of parliamentary procedure.

B. The Primary Rights. A Delegate member has a right to:
1. Offer in the proper manner any motion which he or she may consider to be wise;
2. Explain or debate a motion unless the parliamentary rules prohibit;
3. Call for a point of order;
4. Hold the floor when legally obtained until he or she has finished speaking unless time limits prevail;
5. Appeal from the decision of the Speaker to that of the House.

III. Calendar

All reports of commissions and officers and resolutions are printed in the handbook or distributed on site. Each item of business will be listed on the Calendar, as prepared by NDMA staff, for (1) information only, or (2) as an Action Item for referral to the Reference Committee of the Whole. When considering the Calendar in the first session, the House of Delegates may add or recategorize items.

IV. The Reference Committee of the Whole

The Speaker shall appoint a Reference Committee of the Whole for the House of Delegates. In making appointments, the Speaker will try to provide geographic balance. The Speaker shall appoint a Chairperson from among the members of the Reference Committee.

The Reference Committee is seated in the front during the open testimony portion of the House of Delegates. The Chairperson will conduct the open hearing during which time each action item on the Calendar will be presented. The Chairperson will then offer opportunities to support or oppose and explain why or raise questions about each item. Any member of the NDMA may participate in this open session--not just delegates. Members of the Reference Committee are responsible for carefully listening to all testimony. When all testimony is heard on all items, the open session will end.

The Reference Committee will then go into executive session. During the executive session the Committee will discuss the testimony heard and decide how they will recommend the House of Delegates act on each item. The chairperson prepares the report of the Reference Committee of the Whole. The report is then considered during the final Session of the House, and each item is acted upon by the Delegates.

V. Recommendations and Actions of the House of Delegates

Each recommendation forwarded by the Reference Committee of the Whole should be in the following form and be dealt with by the House of Delegates during the Final Session:

A. Motion to File (information or commendation)
B. Motion to Adopt (all, in part, amended, substitute)
C. Motion to Postpone (to definite time, indefinitely)
D. Motion to Refer (to whom, for what purpose, report back)
E. Motion to Not Adopt (not endorsed or implemented)

Policy Development

For General Information Only

The House of Delegates is the policy making body for the North Dakota Medical Association. The policy is developed by action on Reference Committee Reports. The Reference Committee recommends action after reviewing reports from Officers, Commissions, and the Council, and Resolutions from Delegates or District Societies.

Recommendations from the Reference Committee should be concise so a clear decision can be made by the House.

Options available to the House of Delegates:

1. Resolutions or Commission recommendations are adopted.

2. Resolutions or Commission recommendations are rejected.

3. Reports can be reviewed and filed for information.

4. Resolutions or Commission recommendations can be referred to Commissions or Council for study or implementation.

5. Final action on a Resolution or Commission recommendation may be postponed for future meetings.

If a Resolution or Recommendation is adopted it becomes part of the policy of the Association.

North Dakota Medical Association 2013-14
Officers and Councillors

Officers

President	Steven P. Strinden, MD, Fargo
Vice President	Debra A. Geier, MD, Jamestown
Secretary-Treasurer	Fadel E. Nammour, MD, Fargo
Speaker of the House	Misty K. Anderson, DO, Valley City
Immediate Past-President	A. Michael Booth, MD, Bismarck
Delegate to AMA	Robert W. Beattie, MD, Grand Forks
Alternate Delegate to AMA	Shari L. Orser, MD, Bismarck

Councillors

Terms Expiring in 2014	
First District	Stephanie K. Dahl, MD, Fargo
First District	Harjinder K.Virdee, MD, Fargo
Second District	Vacant
Third District	Randolph E. Szlabick, MD, Grand Forks
Third District	Rory D. Trottier, MD, Grand Forks
Fourth District	Steven R. Mattson, MD, Minot
Sixth District	Mark W. Rodacker, MD, Bismarck
Seventh District	Sarah L. Schatz, MD, Jamestown (unexpired term)
Eighth District	Joseph E. Adducci, MD Williston
Ninth District	Dennis W. Wolf, MD, Dickinson
Tenth District	Timothy J. Luithle, MD, Hillsboro
Councillors Elected in 2014	
Fourth District	Steven R. Mattson, MD, Minot
Sixth District	Laura M. Gehrig, MD, Bismarck
Eighth District	Joseph E. Adducci, MD Williston
Tenth District	Timothy J. Luithle, MD, Hillsboro
Terms Expiring in 2015	
Fifth District	Misty K. Anderson, DO, Valley City
Sixth District	Shelly A. Seifert, MD, Bismarck
Eleventh District	Catherine E. Houle, MD, Hettinger
Terms Expiring in 2016	
First District	Neville M Alberto, MD, Fargo
Terms Expiring in 2017	
Fourth District	Steven R. Mattson, MD, Minot
Sixth District	Laura M. Gehrig, MD, Bismarck
Eighth District	Joseph E. Adducci, MD Williston
Tenth District	Timothy J. Luithle, MD, Hillsboro

Council Officers

Debra A. Geier, MD, Jamestown, Chair
Stephanie K. Dahl, MD, Fargo, Vice-Chair

NDMA 2014 Members of the House of Delegates

First District (43)

Delegates

Name	City
Neville M Alberto MD	Fargo
Steffen P Christensen MD	Fargo
Stephanie K Dahl MD	Fargo
Jau-Shin Lou MD	Fargo
Timothy J Mahoney MD	Fargo
Fadel E Nammour MD	Fargo
Barbara A Sheets Olson MD	Lisbon
Steven P Strinden MD	Fargo

Second District (2)

Delegates

Third District (17)

Delegates

Name	City
Norman T Byers MD	Grand Forks
Robert D McCartney MD	Grafton
Kevin Mork MD	Grand Forks
Rolf R Paulson MD	Grand Forks
Rory D Trottier MD	Grand Forks
Joshua Wynne MD	Grand Forks

Fourth District (3)

Delegates

Name	City
Paul A Bahal MD	Minot
Kimberly T Krohn MD	Minot
Steven R Mattson MD	Minot

Fifth District (1)

Delegate

Genevieve M Goven MD — Valley City

Alternate Delegate

Misty K Anderson DO — Valley City

Sixth District (16)

Delegates

Name	City
A Michael Booth MD	Bismarck
Walter E Frank MD	Bismarck
Raymond S Gruby MD	Bismarck
Steven K Hamar MD	Bismarck
Gaylord J Kavlie MD	Bismarck
Shari L Orser MD	Bismarck

Seventh District (1)

Delegate

Sarah L Schatz MD — Jamestown

Alternate

Debra A Geier MD — Jamestown

Eighth District (1)

Delegates

David N Skurdal MD — Williston

Ninth District (1)

Delegate

Amy Oksa MD — Dickinson

Alternate

Kamille S Sherman MD — Dickinson
Dennis E Wolf MD — Dickinson

Tenth District (1)

Delegate

James G Mehus MD — Mayville

Alternate

Jane DB Ostlie MD — Mayville

Eleventh District (1)

Delegate

The 2014 NDMA House of Delegates is comprised of 87 delegates and alternate delegates; and 13 specialty delegates.

2014 Specialty Society Delegates

The following specialty societies have requested representation in the House of Delegates, have received approval from the House of Delegates, and are entitled to one delegate:

ND Academy of Family Physicians

ND Chapter-American Academy of Pediatrics

ND Chapter-American College of Emergency Physicians

ND Chapter-American College of Physicians

ND Chapter-American College of Radiology

ND Chapter-American College of Surgeons

ND Orthopedic Society

ND Osteopathic Association

ND Psychiatric Society
Emmet Kenney Jr MD Fargo

ND Society of Anesthesiologists

ND Society of Eye Physicians and Surgeons

ND Society of Obstetrics and Gynecology
Steffen P Christensen MD Fargo
Kristen E Cain MD (alternate) Fargo

ND Society of Pathologists

Substantive Policies (2000-2014)
By Subject

Advance Care Planning
Antitrust
Board of Medical Examiners
Ethics
Health Care System
Health Care Workforce
Health Information Technology
Health Insurance
Hospitals/Medical Staff
Medicaid
Medical Liability
Medical School
Medicare
No-Fault Automobile Insurance
North Dakota Medical Association
Patient Rights
Patient Safety
Pay For Performance
Physician Practice
Prescription Drugs
Public Health
Quality
Scope of Practice
Workforce Safety & Insurance

Advance Care Planning
(2010 HOD) Urged North Dakota physicians and other health care professionals across all health care settings consider Physician-Ordered Life-Sustaining Treatment (POLST) components in developing initiatives to ensure that a seriously ill person's wishes regarding life-sustaining treatments are known, communicated, and honored across all health care settings, and urging the Commission on Ethics to continue discussions and serve as a focal point for making POLST available as a tool for North Dakota physicians and healthcare facilities, including consideration of whether a standardized POLST form could be used throughout North Dakota.

1/27/09 (Council) Support bill for health care record registry (SB 2237) and bill revising the Uniform Anatomical Gift Act (SB 2195).

(2008 HOD) Adopted general policy position relating to the following state legislation: "Support ways to enhance patient decision making (health care directives)."

1/25/07 (Council) Adopted general policy position relating to the following state legislation: "Support ways to enhance patient decision making (health care directives)."

1/25/07 (Council) Supported bill to adopt the Revised Anatomical Gift Act (SB 2163).

1/25/07 (Council) Supported bill to authorize principal to allow agent under health care directive to make health care decisions when principal has capacity to make decisions (SB 2308).

1/25/07 (Council) Supported bill to remove the explanation requirement on health care directive appointments for long term care and hospital patients (SB 2212).

1/25/07 (Council) Agreed to monitor a bill encouraging umbilical cord blood donations, with concern over onerous education requirements (HB 1232).

(2004 HOD) Supported revisions to the state's advance directive statutes to combine the living will and durable power of attorney forms (Commission on Ethics).

Antitrust
(2002 HOD) Supported federal antitrust reform legislation (HR 3897).

Board of Medical Examiners
1/27/09 (Council) Oppose bill that would require physicians as a condition of licensure and license renewal to take a geriatrics course (HB 1374).

(2007 HOD) Adopted a resolution requesting the North Dakota Board of Medical Examiners to engage in a joint study, or mutual studies, with NDMA regarding the North Dakota Medical Practice Act and the impact of current statutory language on scope of practice issues.

1/25/07 (Council) Agreed to oppose "alternative therapies" legislation (HB 1327).

11/30/06 (Council) Adopted motion to urge ND Board of Medical Examiners to follow a principled approach in initiating changes to its website, particularly with respect to physician profiling.

(2006 HOD) Urged the North Dakota Board of Medical Examiners to hire a qualified physician to the position of Board executive secretary.

(2003 HOD) Adopted a resolution supporting the current position of the American Medical Association in opposition to the National Board of Medical Examiners proposal to implement a Clinical Skills Assessment Exam as part of the United States Medical Licensure Examination, and supports the continued testing of medical students' clinical skills during their training years in medical school, such as is currently done at the University of North Dakota School of Medicine and Health Sciences, and the alternative of accrediting the skills assessment and testing process currently being utilized at medical schools. The resolution also called for NDMA to solicit support of this position from the North Dakota Board of Medical Examiners.

(2002 HOD) Supported legislation clarifying appropriate public disclosure of information in ND Board of Medical Examiner disciplinary proceedings.

(2001 HOD) Called on NDMA to continue its study of physician due process rights in disciplinary proceedings of the North Dakota State Board of Medical Examiners.

6/8/00 (Council) Motion carried to direct the Executive Director to send a letter to the North Dakota State Board of Medical Examiners expressing privacy concerns and urging that the board remove any date of birth information regarding physicians from the board's website.

(2000 HOD) Resolved that the NDMA Commission on Legislation and Governmental Relations study physicians' statutory due process rights in disciplinary proceedings before the North Dakota State Board of Medical Examiners, and that the Commission report its findings to the NDMA Council for further consideration and possible legislative action before the start of the 2001 North Dakota Legislative Assembly.

Ethics
1/25/07 (Council) Adopted motion accepting recommendation of Commission on Ethics to encourage the ND Pharmacy Association to urge North Dakota pharmacies to stock Plan B in their pharmacies as a behind the counter medication for women 18 and older with language that "in the event that an individual pharmacist or pharmacy refers a patient to an alternate dispensing source, the individual pharmacist or pharmacy chain must return the prescription to the patient and should notify the prescribing physician of the referral."

(2006 HOD) Encouraged the ND Pharmacy Association to urge North Dakota pharmacies to stock Plan B in their pharmacies as a behind the counter medication for women 18 and older.

4/25/02 (Council) Motion carried that NDMA participate as a signatory on the AMA's Declaration of Professional Responsibility: Medicine's Social Contract with Humanity.

Health Care System
(2010 HOD) Adopted resolution urging NDMA to advocate for amendments and modifications to the Patient Protection and Affordable Care Act regarding those provisions that are inconsistent with NDMA policy and to assist physicians in evaluating opportunities to participate in demonstration programs and other opportunities under the health system reform law.

(2009 HOD) Adopted resolution urging the medical community, including psychiatrists and primary care physicians and the UND School of Medicine & Health Sciences and residency programs and NDMA, to work together with others to address the availability of medically-based psychiatric services in the state.

(2009 HOD) Adopted resolution on national health system reform and Medicare payment reform. The resolution urged the North Dakota Congressional Delegation as part of health system reform to pursue multiple avenues for Medicare physician and hospital payment reform that address the unfair disparity in Medicare payments to North Dakota as recommended by the joint NDMA/NDHA Medicare Payment Task Force; supporting efforts of Senator Kent Conrad to initiate a Centers for Medicare and Medicaid (CMS) demonstration project to pilot rural models of health care delivery in North Dakota that focus on creating an accountable state system of care, assistance for health care infrastructure development, and fair payment for the provision of physician and hospital services; and urging the United States Congress to enact meaningful health system reform that ensures access by people in North Dakota to health care and enhances high quality, cost-efficient medical care.

(2008 HOD) Adopted general policy position relating to the following state legislation: Support expanded coverage for uninsured and underinsured people, including children.

(2008 HOD) Adopted a resolution urging NDMA to support the concept of a patient-centered medical home as a means to improve the quality of care and reduce health care costs; and to continue to study the various medical home proposals and take appropriate advocacy action that best serves the interests of North Dakota physicians and patients.

(2008 HOD) Supported preliminary state 2009 legislative agenda: Support trauma system reform priorities (SB 2048).

(2007 HOD) Accepted Council recommendation to support the Statewide Vision and Strategy for Healthcare in 2020.

1/25/07 (Council) Adopted general policy position relating to the following state legislation: "Support a comprehensive study of the ND trauma system."

1/25/07 (Council) Supported bill for ND Trauma System study by the American College of Surgeons (HB 1290).

11/30/06 (Council) Adopted motion to support (including financial support) process for statewide vision and strategy for the North Dakota healthcare system.

11/30/06 (Council) Adopted motion to support (including financial support) NDMA participation in Innovative Care Coalition Demonstration project incorporating "medical home" concept.

(2000 HOD) Resolved that NDMA urge the State Health Council to amend its proposed changes to administrative rules for the North Dakota Trauma System, which would require transport to certain trauma centers. The proposed NDMA language, rather than mandating that patients be taken by EMS personnel to the trauma center with the highest level designation, would require that the patient be taken to the trauma center "with the appropriate level of trauma care." The resolution also urged the Health Council to require that scope of practice

of a trauma team leader in a level V trauma center who is a physician assistant or nurse practitioner be approved by the ND Board of Medical Examiners and/or the ND Board of Nursing.

Health Care Workforce

(2009 HOD) Adopted resolution for NDMA to study J-1 waiver opportunities and their utilization in North Dakota; and to support efforts to allow J-1 waivers to be used for academic positions.

(2009 HOD) Adopted resolution for NDMA to study issues important for the retention of graduating North Dakota resident physicians in positions in the state and to support efforts to retain them; and to support efforts to retain North Dakota-trained residents in the state, and that NDMA study and urge appropriate changes in North Dakota medical licensure laws to remove disincentives for residents who are graduates of international schools to remain in the state.

(2009 HOD) Adopted resolution supporting the expansion of family medicine residency positions in North Dakota through support of both federal and state legislation and/or other policy advocacy to initiate and fund these positions.

(2009 HOD) Adopted resolution urging the medical community, including psychiatrists and primary care physicians and the UND School of Medicine & Health Sciences and residency programs and NDMA, to work together with others to address the availability of medically-based psychiatric services in the state.

(2008 HOD) Adopted resolution supporting continued study and development of a report on North Dakota's physician workforce for completion by the end of 2008, and urging policymakers to consider any resulting recommendations.

(2008 HOD) Adopted resolution urging NDMA along with the UNDSMHS Center for Rural Health to work together to investigate retention methods and improving satisfaction among physicians working in rural settings.

(2008 HOD) Adopted general policy position relating to the following state legislation: Support efforts to enhance North Dakota's workforce climate for physicians and other health professionals / Support initiatives to address physician workforce issues.

(2007 HOD) On a resolution urging the North Dakota Department of Health or other appropriate state agency to study mental health accessibility for the citizens of North Dakota, referred the resolution to the Commission on Medical Services to review, in conjunction with the ND Psychiatric Society, recommendations from the ND Department of Human Services resulting from the Mental Health Workforce conference.

(2006 HOD) Supported a resolution supporting the ND Department of Health's budget request for an appropriation to the physician loan repayment program, and calling for minimum funding of $300,000.

(2006 HOD) Urged North Dakota policymakers to maintain an environment in North Dakota that assures an adequate supply of physicians and other health professionals—both in number and in mix—to care for all residents, and to secure additional funding for the UND School of Medicine & Health Sciences to ensure the appropriate supply of physicians and other health professionals to serve all residents of North Dakota.

9/27/03 (Council) Motion carried that the Commission on Medical Education review all options relating to medical student loan repayment alternatives, including existing programs, and develop recommendations for the Council.

(2003 HOD) Adopted recommendation that NDMA consider the development of a medical student loan repayment program to financially assist graduates of the UND School of Medicine and thereby encourage them to practice in rural North Dakota communities.

(2001 HOD) Expressed support by the First District Medical Society for preserving and enhancing the medical care of patients by supporting the local training of family physicians.

Health Information Technology
(2009 HOD) Adopted resolution urging NDMA to participate fully in state efforts to develop a state health information technology plan and leverage state and federal resources to support connected and interoperable health information technology systems.

1/27/09 (Council) Support bill for creation of state HIT office and advisory committee and leverage federal funds (SB 2332).

(2008 HOD) Adopted general policy position relating to the following state legislation: "Support efforts to encourage strategies and plans for health information technology."

1/25/07 (Council) Adopted general policy position relating to the following state legislation: "Support efforts to encourage strategies and plans for health information technology."

1/25/07 (Council) Supported bill to establish a statewide health information technology committee (SB 2303).

Health Insurance
(2011 HOD) Adopted a resolution that the North Dakota Medical Association adopt principles in preparation of health insurance exchanges to assist the state in the formation of health insurance exchanges; and, communicate these principles including physician representation on the governance Board to the North Dakota State Legislature and the Health Care Reform Interim Legislative committee.

(2009 HOD) Adopted resolution urging NDMA to consider pursuing legislation similar to Minnesota requiring the use by payors of a uniform pre-authorization or formulary exception form (Minn. Stat. 62J.497(4)) and urging Medicare Part D providers to adhere to the following principles in the design of their pre-authorization procedures:

1. Physicians should be provided with a streamlined method of submitting a pre-authorization request; long phone hold times should not be used as a method of deterring pre-authorization efforts. If a form is required, it should be readily available without a phone call.
2. Decisions about pre-authorization requests should be produced in a timely manner and should include clear information about appeal processes. Non-physicians should not be making final appeal decisions.
3. Enrollees should be provided with clear information about coverage of medications by their Part D provider.
4. Medications new to the market should not be automatically required to pass through a pre-authorization process without an evaluation of costs and benefits.
5. Appeals because of individual patient characteristics should be available and carefully considered for all enrollees.

(2009 HOD) Adopted resolution urging interim committees of the North Dakota Legislative Council, the Commissioner of Insurance, commercial insurers and others to address physician concerns regarding the cost of health insurance and unmet health care needs in the state, including the need for imposing fair contracting standards on commercial health insurers, facilitating more competition in the health insurance market in North Dakota, and recognizing that physician and hospital payments and health insurance premiums of BlueCross BlueShield of North Dakota are much lower than commercial insurers in states in our region.

1/27/09 (Council) Support bill to expand SCHIP eligibility to 200% of poverty net; Support bill to prohibit exclusion of insurance coverage for injuries resulting from intoxication (HB 1204). Oppose bill revise the premium rate filing process for commercial insurers (SB 2306). Support revision to bill to require identification of specific internal appeal processes need to be exhausted in order to use the external independent review process (SB 2774).

(2008 HOD) Adopted resolution urging commercial health insurers and the North Dakota Commissioner of Insurance, in review of premium rates for health insurance policies, to more formally consider appropriate statewide standards for physician and hospital payments consistent with regional commercial market, and for the Commissioner of Insurance to consider standards for commercial insurer contracts with physicians and hospitals that facilitate a fair implementation of insurer policy changes.

(2008 HOD) Adopted as preliminary 2009 state legislative agenda: Support fair commercial insurer contracting standards (SB 2397).

(2008 HOD) Adopted general policy position relating to the following state legislation: Support expanded coverage for uninsured and underinsured people, including children.

(2007 HOD) Adopted a resolution expressing concern over the refund of BlueCross BlueShield of North Dakota “surplus” premiums without full consideration of potential impacts on future premium rates and physician and hospital payment equity.

1/25/07 (Council) Adopted motion to accept recommendations of NDMA Ad Hoc Committee on Preventive Services relating to development of preventive benefits and coverage by BlueCross BlueShield of North Dakota.

1/25/07 (Council) Adopted general policy position relating to the following state legislation: “Support the independent medical judgment of physicians in medical practice; and support expanded coverage for uninsured and underinsured people, including children.”

1/25/07 (Council) Supported bill to expand the eligibility for the State Children’s Health Insurance Program (HB 1463 / HB 1047).

9/15/06 (Council) Adopted motion opposing surplus premium refund by BlueCross BlueShield of North Dakota.

11/30/06 (Council) Confirmed NDMA recommendations to BCBSND to clarify and better communicate roles and functions of their physician advisory committees: CMAC, MCRAC, PsychRAC and others to provide more transparency with clear, periodic updates for the physician community.

(2006 HOD) Expressed concern over increasing profits accumulated by BlueCross BlueShield of North Dakota and urging the BlueCross BlueShield of North Dakota Board of Directors to make 2007 payment adjustments that recognize increasing physician practice costs, including necessary capital costs and recruitment needs, and to fully disclose how any other methodology adjustments diminish 2007 updates on a statewide basis. (Council included amendment language calling for a portion of any “surplus dividend” to be used for physician and hospital reimbursement enhancements in addition to regular 2007 payment adjustments.)

1/28/05 (Council) Supported legislative proposal to establish independent review mechanism for appealing adverse decisions made by health plans.

(2005 HOD) Adopted a resolution urging the BlueCross BlueShield of North Dakota Board of Directors to make 2006 payment adjustments that recognize increasing physician practice costs and the value of physician services, and to fully disclose how other methodology adjustments diminish 2006 updates on a statewide basis.

(2005 HOD) Reaffirmed support for efforts to achieve parity in insurance coverage for mental health care.

(2005 HOD) Reaffirmed need for continued advocacy for BlueCross BlueShield of North Dakota payment increases that recognize increasing physician practice costs.

(2004 HOD) Supported efforts to achieve parity in insurance coverage for mental health care.

(2004 HOD) Continued advocacy for BlueCross BlueShield of North Dakota payment increases that recognize increasing physician practice costs.

9/25/03 (Council) Motion carried to approve draft comments on the BCBSND 2004 payment proposals.

(2003 HOD) Adopted a resolution calling on NDMA to request that the BlueCross BlueShield of North Dakota Board of Directors initiate a study of the health and financial impact of coverage for preventive health care services, including screening sigmoidoscopy, barium enema, and colonoscopy for the prevention of colon cancer which would reduce future health care costs.

(2003 HOD) Continue advocacy for BlueCross BlueShield of North Dakota payment increases that recognize increasing physician practice costs.

(2002 HOD) Expressed support for the candidacy of Rhonda Ketterling, MD, for election to the BCBSND Board of Directors in 2002.

(2002 HOD) Expressed to the BCBSND Board of Directors NDMA's deep concerns with revisions to the corporate bylaws which allow the nomination and election of an individual who is neither in active practice as a licensed healthcare professional nor a healthcare executive to represent the healthcare industry on the Board of Directors.

(2002 HOD) Supported legislation establishing an independent review mechanism in current proposals for revamping ND's insurer utilization review statute.

(2002 HOD) Supported continued consideration for revisiting NDMA's draft 2001 legislation imposing fair contracting standards on insurers.

6/8/00 (Council) In response to public forums held across the state by BlueCross BlueShield of North Dakota, motion carried that an editorial viewpoint for the media be prepared by the NDMA President for Council review and use as appropriate. Motion carried to direct the president to meet with the BCBSND CEO, share the proposed editorial, and discuss the issues raised at the BCBSND community forums. Motion carried to suggest to the BCBSND CEO that he also include the physician members of the BCBSND board of directors in the discussion if he desires.

6/8/00 (Council) Motion carried to pursue to the extent possible recommendations of the Commission on Socio Economics regarding a series of strategies to address ongoing healthcare reform efforts and insurer contracts:

1. That the NDMA staff, in a manner consistent with state and federal law, provide for review of insurer contracts, including BCBSND's PNO agreements and the physician participation agreement. NDMA staff should contact AMA's Private Sector Advocacy Group for advice.
2. That NDMA continue efforts to ensure that state insurance laws are enforced through the North Dakota Insurance Department.
3. That NDMA President and staff initiate dialogue with North Dakota business leaders.

4. That NDMA continue its proactive approach with legislative initiatives to address insurer issues.
5. That NDMA encourage insurers to allow physicians to provide advice on benefit design issues, encourage wellness programs, and impact patient-related behavior.
6. That NDMA develop a white paper identifying physician themes relating to the health reform efforts, including concerns about recruiting physicians to North Dakota, access to appropriate medical services, and the inappropriateness of linking the BCBSND budgetary process with prescription drug utilization.

(2000 HOD) Resolved that NDMA continue its efforts to respond on behalf of North Dakota physicians to public views expressed by BlueCross BlueShield of North Dakota on the future of medical care.

(2000 HOD) Resolved that NDMA develop a "hassle log" on the NDMA web site where physicians can direct e-mail the Association with concerns regarding the practices of third party payors.

(2000 HOD) Accepted report for legislative proposals:
1. Pursue legislation strengthening North Dakota standards for utilization review performed by insurers.
2. Pursue legislation prohibiting insurers from requiring physicians to participate in any insurance product as a condition for participating in the insurer's other products (all-products or "contract stacking" policies).
3. Compare provisions in insurer contracts with the provisions of the AMA's Model Managed Care Contract for education purposes.
4. Work with NDMGMA in pursuing legislation, if necessary, to eliminate insurer payment delays due to subsequent premium nonpayment.
5. Review the need for disclosure by insurers of drug formulary policies and their rationale for formulary decisions, including disclosure of rebates to insurers by pharmaceutical companies.

Hospitals/Medical Staff
1/25/07 (Council) Adopted general policy position relating to the following state legislation: "Support the independent medical judgment of physicians in medical practice."

4/4/06 (Council) Adopted a motion calling on ND Department of Health to address inadequate survey team understanding of medical staff bylaws and procedures, particularly in rural areas of the state.

1/28/05 (Council) Adopted motion that NDMA participate and assist in planning an economic credentialing dialogue with the ND Healthcare Association.

Medicaid
1/29/13 (Council) Support Medicaid expansion (HB 1362) during the 2013 ND legislative session.

1/25/11 (Council) Support 3% inflationary increases in physician Medicaid payments and advocate for further rebase of physician payments to 100% of cost, and advocate that ND Legislative Assembly adhere to its own statement of legislative intent in the 2009 session that physician payments be made at cost. (SB 2012).

1/27/09 (Council) Support bill to establish a Legislative Council Medicaid Committee (SB 2337).

(2008 HOD) Adopted general policy position relating to the following state legislation: Support Medicaid payment increases for physicians and hospitals / support Medicaid physician payment rebase to actual cost / support Medicaid program management reforms.

(2008 HOD) Adopted a resolution urging the Governor and the 2009 North Dakota Legislative Assembly to support steps to rebase Medicaid physician payments to actual cost based on the findings and conclusions of the state's consultant.

(2007 HOD) Adopted a resolution calling for evaluation of Medicaid payments and for fair Medicaid payments that allow health systems to survive in the future.

1/25/07 (Council) Adopted general policy position relating to the following state legislation: "Support Medicaid payment increases to the Medicare level; and support Medicaid program and management reforms."

1/25/07 (Council) Supported bill for deficiency appropriation for the Medicaid Management Information System (SB 2034).

1/25/07 (Council) Supported bill to establish a legislative Medicaid committee (HB 1404).

1/25/07 (Council) Supported bill to prohibit the Medicaid Drug Use Review Board from prior authorizing or restricting single-source or brand name antipsychotic, antidepressant, or other medications used to treat mental illnesses, such as schizophrenia, depression, or bipolar disorder, and drugs prescribed for the treatment of acquired immune deficiency syndrome or human immunodeficiency virus, and cancer (HB 1422).

(2006 HOD) Reaffirmed support to address the continuing inadequate reimbursement of physicians and hospitals by the ND Medicaid program.

(2005 HOD) Adopted a resolution calling on the Governor and legislative leaders to take steps to address the unfairness of state Medicaid rates that do not cover practice costs for physicians and hospitals.

(2005 HOD) Reaffirmed support for federal Medicaid reforms that enhance financial support for North Dakota.

(2004 HOD) Adopted a resolution calling on the Governor of North Dakota to initiate the process for using the remaining federal funds available for the Medicaid program under the Jobs and Growth Tax Relief Reconciliation Act of 2003 in the current 2003-05 biennium for physician and hospital payment rate increases; and if the Governor is unsuccessful in allocating new FMAP funds for physician and hospital payment increases in the current biennium, that priority be given in the executive budget proposal to use of federal funds made available to North Dakota pursuant to the Jobs and Growth Tax Relief Reconciliation Act of 2003 to address the expected decrease in FMAP in the 2005-07 biennium.

(2004 HOD) Supported federal Medicaid reforms that enhance financial support for North Dakota.

(2004 HOD) Improve the ND Medicaid program pursuant to recommendations made by the Governor's Medicaid Working Group, and closely monitor and act as necessary in legislative deliberations on the 2005-07 Medicaid budget.

Medicaid Management: The primary recommendations call for *expanding the role and composition of the Medical Care Advisory Committee* to report directly to the Governor and legislative leaders at least annually on all aspects of the Medicaid program, including reviews of fee schedules and program expenditures, program administration, enrollment, service utilization and other program trends, and clinical performance.

Medicaid Budget Process and Payments: The recommendations also call for the development of *actuarially-based methodologies* for studying Medicaid payment rates and developing agency budget recommendations, performing and reviewing data analyses, tracking program service utilization, and determining the effectiveness

of quality and cost containment initiatives. The recommendations call for addressing the expected decrease in the federal medical assistance percentage (FMAP), including the need for allocation of new funds.

Medicaid Administrative Functions: The recommendations also recognize the current *inadequacy of the state's Medicaid infrastructure for technology and personnel*, and include serious consideration for *outsourcing current administrative functions* to experienced entities subject to adequate protections for maintaining Department of Human Services control of medical and utilization information.

Medicaid Benefits and Eligibility: The recommendations call on the state to *strike an appropriate balance between the needs of recipients, the state's ability to pay, and health care providers' ability to absorb the cost of providing services*. This would include a review by the Medical Care Advisory Committee of the current benefit and eligibility program to determine the appropriateness of the current level of mandatory and optional services, and recognition that changes in Medicaid benefits and eligibility thresholds should not be made until an actuarial assessment and cost-benefit analysis are completed and revenue sources identified.

Medicaid Prescription Drug Benefits: Another major recommendation calls for ensuring access to medically necessary prescription drugs *without undue administrative burdens*. The recommendations call on the Department of Human Services to redirect its cost containment strategy from one of identifying drug categories for prior authorization to the establishment of an *evidence-based preferred drug list*.

(2003 HOD) Adopted a resolution calling on NDMA to support efforts to sustain the Medicaid program in North Dakota, including use of federal relief for restoration of previous provider payment cuts, and active participation by NDMA in the Governor's Medicaid Task Force and the Legislative Council's interim Medicaid study.

8/12/02 (Council) Motion carried that NDMA actively participate with state officials in addressing budget shortfalls in the Medicaid program and ensure that there is adequate physician input in those matters.

(2002 HOD) Reaffirmation of NDMA's work with the ND Healthcare Association, state representatives (DHS, Governor), and the ND Medical Group Management Association to identify both short and long-term solutions for the Medicaid budget shortfall, including additional sources of funding; elimination of patient misuse of the program; and focus on appropriate provider education efforts.

Medical Liability
1/27/09 (Council) Oppose bill to repeal the cap on non-economic damages in medical liability actions (HB 1390); and support Uniform Emergency Volunteer Health Practitioners Act in 2009 ND Legislative Assembly (HB 1073).

(2008 HOD) Adopted as preliminary 2009 state legislative agenda: Support changes to the Good Samaritan Law / Support changes to the medical liability certificate of merit law relating to motions for extension of time (HB 1302) / Recommend no further action on exploration of pre-trial panels, arbitration and health courts.

(2008 HOD) Adopted general policy position relating to the following state legislation: Support additional state medical liability reforms and protect existing reforms.

(2007 HOD) Adopted a resolution directing NDMA to revise the North Dakota Good Samaritan Law to protect physicians and other health practitioners who respond to public health threats and emergencies and to address recent interpretations of the law by the North Dakota Supreme Court.

(2007 HOD) Adopted a resolution directing the NDMA Commission on Legislation and Council to study options for pre-trial screening panels, arbitration/mediation, and health courts as an alternative to the current medical liability system and to provide recommendations to the 2008 House of Delegates.

1/25/07 (Council) Adopted general policy position relating to the following state legislation: “Support additional state medical liability reforms – protect existing reforms.”

(2006 HOD) Supported new medical liability “I’m Sorry” legislation, to allow physicians to express empathy with their patients in the event of an unintended outcome of the care they have provided without the expression being used negatively in a subsequent liability lawsuit against the physician.

1/28/05 (Council) Opposed legislative proposal for mandatory alternative dispute resolution for professional malpractice claims.

(2005 HOD) Reaffirmed support for meaningful federal tort reform legislation.

(2004 HOD) Supported meaningful federal tort reform legislation.

(2004 HOD) Supported revision of NDCC Section 28-01-46 to clarify the expert witness opinion requirements in medical liability cases.

(2003 HOD) Adopted a resolution urging the North Dakota Congressional Delegation to support medical liability reform legislation similar to H.R. 5, as passed in the U.S. House and supported by Congressman Pomeroy, which would allow injured patients to recover unlimited economic damages; limit attorneys' contingent fees on a sliding scale; cap non-economic damages at $250,000 for those states without a cap; and allocate damages by holding defendants liable only for their portion of responsibility.

(2003 HOD) Reaffirmed support for federal tort reform legislation (HR 5).

(2002 HOD) Supported federal tort reform legislation (HR 4600).

(2001 HOD) Adopted a resolution calling for a study of the availability of affordable medical liability insurance in North Dakota.

Medical School
(2012 HOD) Support expansion/construction of new medical school in pursuit of greater retention of graduates and increasing the number of providers in the state.

(2011 HOD) adopted a resolution that North Dakota Medical Association support research into current programs to retain physicians graduating from residencies in North Dakota through support of both federal and state legislation and/or other policy advocacy to initiate and fund the incentives.

1/25/11 (Council) Support bill to reduce post graduate training from 36 to 30 months for international medical graduates for purposes of full and unrestricted license (HB 1222)

1/25/11 (Council) Support proposal “Growing Our Own Doctors (GOOD)” including expansions in medical class size and residency positions; oppose use of tobacco settlement funds for this purpose (HB 1353)

(2009 HOD) Adopted resolution for NDMA to study issues important for the retention of graduating North Dakota resident physicians in positions in the state and to support efforts to retain them; and to support efforts to retain North Dakota-trained residents in the state, and that NDMA study and urge appropriate changes in North Dakota medical licensure laws to remove disincentives for residents who are graduates of international schools to remain in the state.

(2009 HOD) Adopted resolution supporting the expansion of family medicine residency positions in North Dakota through support of both federal and state legislation and/or other policy advocacy to initiate and fund these positions.

1/27/09 (Council) Support UNDSMHS appropriation (SB 2003) including additional requests:
-College affordability funding to limit tuition increases ($767,427),
-Development of a comprehensive health care delivery plan for North Dakota ($707,850),
-Establishment of a new MPH degree program ($1,133,600),
-Establishment of an enhanced geriatrics training and care delivery program ($1,074,450),
-Funding for planning, land acquisition, and construction of a new facility for the Bismarck Center for Family Medicine (over $5,000,000),
-Retire the bond for the existing Minot CFM building ($4,000,000).
Also support bills addressing UNDSMHS performance audit on UNDSMHS purpose (SB 2079), student loan program (SB 2077) and UNDSMHS Advisory Council duties (SB 2081).

(2008 HOD) Adopted general policy position relating to the following state legislation: “Support increases in the Medical School budget” Adopted as preliminary 2009 state legislative agenda: Support changes to statutes relating to UNDSMHS purpose, advisory council, and student loan fund.

1/25/07 (Council) Adopted general policy position relating to the following state legislation: “Support increases in the Medical School budget.”

(2006 HOD) Urged North Dakota policymakers to maintain an environment in North Dakota that assures an adequate supply of physicians and other health professionals—both in number and in mix—to care for all residents, and to secure additional funding for the UND School of Medicine & Health Sciences to ensure the appropriate supply of physicians and other health professionals to serve all residents of North Dakota.

(2004 HOD) To increase the incentives for completing medical school and residency training in North Dakota, and initiating practice in a North Dakota community, supported NDMA working with the School of Medicine during the 2005 Legislative Session to seek legislative support and increased appropriations to help constrain or limit the future costs of attending medical school at the UND School of Medicine and Health Sciences. NDMA should also work with the ND Health Department during the 2005 Legislative Session to increase the annual limits of the funding assistance allowed under the state physician and community loan forgiveness program law (NDCC Chapter 43-17.2). For physicians who are participating in the ND physician and rural community loan forgiveness program, NDMA should develop a means to provide additional loan repayment funds under a separate agreement with the participating community and physician, to substantially increase the current amount available to the physician beyond the program's $40,000 maximum amount over a four-year period.
(2000 HOD) Resolved that NDMA fully support the candidacy of Dean H. David Wilson for the Council on Medical Education of the American Medical Association, and that the North Central Medical Conference be urged to support Dean Wilson’s candidacy for the Council on Medical Education.

Medicare
(2013 HOD) adopted resolution to urge our Congressional Delegation to work with Congress to repeal provisions of Section 3403 of the Patient Protection and Affordable Care Act that establish the Independent Payment Advisory Board.

(2011 HOD) adopted a resolution to support retention of the frontier states amendment of patient protection and affordable care act until such time that Medicare reimbursement becomes equitable, eliminating geographic disparity.

(2009 HOD) Adopted resolution urging Medicare Part D providers to adhere to the following principles in the design of their pre-authorization procedures:

1. Physicians should be provided with a streamlined method of submitting a pre-authorization request; long phone hold times should not be used as a method of deterring pre-authorization efforts. If a form is required, it should be readily available without a phone call.
2. Decisions about pre-authorization requests should be produced in a timely manner and should include clear information about appeal processes. Non-physicians should not be making final appeal decisions.
3. Enrollees should be provided with clear information about coverage of medications by their Part D provider.
4. Medications new to the market should not be automatically required to pass through a pre-authorization process without an evaluation of costs and benefits.
5. Appeals because of individual patient characteristics should be available and carefully considered for all enrollees.

(2009 HOD) Adopted resolution on national health system reform and Medicare payment reform. The resolution urged the North Dakota Congressional Delegation as part of health system reform to pursue multiple avenues for Medicare physician and hospital payment reform that address the unfair disparity in Medicare payments to North Dakota as recommended by the joint NDMA/NDHA Medicare Payment Task Force; supporting efforts of Senator Kent Conrad to initiate a Centers for Medicare and Medicaid (CMS) demonstration project to pilot rural models of health care delivery in North Dakota that focus on creating an accountable state system of care, assistance for health care infrastructure development, and fair payment for the provision of physician and hospital services; and urging the United States Congress to enact meaningful health system reform that ensures access by people in North Dakota to health care and enhances high quality, cost-efficient medical care.

(2008 HOD) Adopted a resolution supporting the effort of the Geographic Equity in Medicare (GEM) Coalition to correct deficiencies in the Medicare physician practice expense geographic practice cost index (GPCI).

(2008 HOD) Adopted a resolution expressing appreciation to the North Dakota Congressional Delegation for their support of a temporary Medicare physician payment fix and to urge continued work on Medicare payment reform that permanently addresses both the Sustainable Growth Rate (SGR) and unfair disparities in payment caused by geographic practice cost indices (GPCIs) and the hospital wage index.

(2007 HOD) Adopted a resolution calling on our United States Senators to take immediate action to ensure that any conference committee agreement on SCHIP reauthorization or other legislation to avert cuts in Medicare physician payments to include at least two years of positive Medicare physician payment updates that do not increase the cost of a permanent solution.

(2007 HOD) Adopted a resolution urging Congress and other policymakers to consider recommendations for major Medicare reforms, including recommendations of the joint statement on Medicare reform to Congress by the American Medical Association and over eighty national specialty societies, recommendations of the Geographic Equity in Medicare Coalition, and recommendations of NDMA.

(2007 HOD) Adopted a resolution calling on NDMA, in concert with our members of Congress, to begin to develop and advance the necessary framework and data to initiate the legislative vehicles to address the underlying payment challenges in North Dakota and other similarly-situated states/geographic regions.

(2006 HOD) Expressed continued physician frustration with having to address each year a proposed Medicare physician payment cut caused by the flawed sustainable growth rate (SGR), and urging the ND Congressional Delegation to support Congressional action before the October adjournment target date to: (1) avert the 5.1% cut for 2007 and enact a 2.8% physician payment update, as recommended by the Medicare Payment Advisory

Commission (MedPAC); and (2) repeal the SGR physician payment system and replace it with a system that adequately keeps pace with increases in medical practice costs.

(2006 HOD) Urged Congress, and the members of North Dakota's Congressional Delegation, to support additional incremental efforts to eliminate or reduce the impact of the geographic practice cost indices (GPCIs) used to calculate Medicare physician payments in North Dakota.

(2005 HOD) Adopted a resolution expressing frustration with having to address each year a proposed Medicare physician payment cut caused by the flawed sustainable growth rate (SGR), and urging the ND Congressional Delegation to support a permanent fix or replacement to the SGR that would begin in 2006.

(2005 HOD) Adopted a resolution urging North Dakota's Congressional Delegation to support H.R. 3617, the "Medicare Value-Based Purchasing for Physicians' Services Act of 2005," which would eliminate the sustainable growth rate component of the Medicare physician payment formula and initiate a principled approach to "value-based purchasing" of medical services.

(2005 HOD) Adopted a resolution urging study and consideration of a regional approach to Medicare payment for quality.

(2005 HOD) Adopted a resolution expressing the frustration of the medical community to our Congressional Delegation in having to annually address proposed cuts in Medicare physician payments resulting from the sustainable growth rate and to urge the Delegation to pursue a permanent fix to the SGR problem while continuing to address payment disparity issues.

(2005 HOD) Reaffirmed support for federal legislation fixing the Medicare physician payment formula, particularly issues relating to the sustainable growth rate (SGR).

(2005 HOD) Reaffirmed support for federal legislation taking additional steps toward elimination of geographic disparity in Medicare physician payments.

(2005 HOD) Supported Noridian's bid as the new Jurisdiction #3 (ND, SD, Montana, Wyoming, Utah, Arizona) Medicare Administrative Contractor (MAC) for Part A and Part B under the new bid process initiated by the 2003 Medicare reform legislation.

(2004 HOD) Supported federal legislation fixing the Medicare physician payment formula, particularly issues relating to the sustainable growth rate (SGR).

(2004 HOD) Supported federal legislation taking additional steps toward elimination of geographic disparity in Medicare physician payments.

(2003 HOD) Adopted a resolution urging Congress, and the members of North Dakota's Congressional Delegation, to support efforts to eliminate the geographic disparity in Medicare physician payments and to replace the Sustainable Growth Rate used in the Medicare physician payment formula with an annual update system like those of other provider groups so that payment rates will better reflect actual increases in practice costs.

(2003 HOD) Reaffirmed support for federal legislation fixing the Medicare payment crisis.

(2003 HOD) Reaffirmed support for federal legislation taking steps toward elimination of geographic disparity in Medicare physician payments.

8/12/02 (Council) Motion carried that NDMA sign on to a joint letter with the North Dakota Healthcare Association to the state's congressional delegation indicating a joint commitment to resolving Medicare reimbursement issues.

4/25/02 (Council) Motion carried that NDMA support a North Central Medical Conference resolution that the AMA pursue a single national Medicare payment schedule which would result in payment equity. AMA subsequently approved the new policy.

(2002 HOD) Supported federal legislation fixing the Medicare payment crisis (three-year fix in HR 4954).

(2002 HOD) Supported federal legislation taking steps toward elimination of geographic disparity in Medicare physician payments (S. 2873) (AMA resolution/GEM Coalition).

No-Fault Automobile Insurance
1/28/05 (Council) Opposed legislative proposal to limit usual and customary charges for medical expenses under no-fault automobile insurance.

North Dakota Medical Association
09/22/11 (Council) Reaffirmed the Commission's position that NDMA discontinue its current intrastate CME program, under the authority of the Accreditation Council for Continuing Medical Education (ACCME).

(2008 HOD) Adopted a bylaws amendment for the creation of an executive committee of the NDMA Council.

(2005 HOD) Adopted a resolution (Sixth District Medical Society) directing the Council to create an ad hoc committee to discuss the NDMA governance structure and annual meeting in lieu of a proposal to eliminate the NDMA House of Delegates and replace it with an annual membership meeting.

(2002 HOD) Adopted a resolution calling for a study of the current status of the District Medical Societies and the impact of that status on NDMA.

(2002 HOD) In bylaws revisions, the House changed the membership delinquency date from April 30 to March 1; and eliminated the NDMA Commission on Physicians' Health.

(2002 HOD) Reaffirmed the Commission's position that NDMA should maintain and consider expanding its current intrastate CME program, under the authority of the Accreditation Council for Continuing Medical Education (ACCME), offering North Dakota entities the opportunity to become and remain voluntarily accredited to provide continuing medical education programming for physicians.

12/19/01 (Council) Motion carried to request the chair of the Commission on Socio Economics (speaking for the commission) to rescind the arrangement for allowing BlueCross BlueShield of North Dakota to have representation on the commission and that issues be addressed by coming together in mutual agreement with BlueCross BlueShield on issues as necessary. NDMA will continue to meet quarterly with BCBSND senior staff and continue other previous arrangements.

9/21/00 (Council) Motion carried to refer a resolution to the NDMA House of Delegates calling for a study of NDMA membership trends and options for increasing membership, including the exploration of whether physicians in North Dakota should consider Association membership as a condition of medical licensure.

9/21/00 (Council) Motion carried to accept the 2000 draft strategic plan and refer to the NDMA House of Delegates.

(2000 HOD) Resolved that the NDMA Council develop and adopt a policy on media relations, including a protocol for media contacts, and that the Commission on Medical Services and Public Relations work with NDMA staff to use the media to advocate for physicians and patients when appropriate.

(2000 HOD) Resolved adoption of the proposed NDMA strategic plan (2000-05).

(2000 HOD) Resolved that the Council and appropriate commissions study NDMA membership trends and options for increasing membership, including consideration of whether NDMA membership should be a condition of medical licensure.

Patients' Rights
(2002 HOD) Supported the AMA-backed federal legislation on patients' rights.

Patient Safety
(2013 HOD) North Dakota Medical Association urge our Congressional Delegation to work with Congress to repeal the existing ban on firearm related research and provide sufficient resources to study firearm related injury data; encourage the development and presentation of gun safety programs that educate the public on the responsible use and storage of firearms; and submit a resolution to the next AMA House of Delegates, if not already under consideration, to repeal the ban on federally sponsored research on gun violence.

(2007 HOD) Support participation by NDMA in a partnership with North Dakota Health Care Review, Inc. and the ND Healthcare Association on quality and patient safety initiatives.

(2006 HOD) Directed NDMA to work with the North Dakota Healthcare Association and North Dakota Health Care Review, Inc. to establish a provider-led North Dakota patient safety organization.

(2004 HOD) Supported appropriate patient safety legislation (S.720).

(2003 HOD) Supported federal patient safety legislation.

Pay for Performance
(2005 HOD) Adopted a resolution expressing the support of NDMA for the American Medical Association Principles and Guidelines for the formation and implementation of pay-for-performance programs.

Physician Practice
(2013 HOD) resolution adopted for NDMA to work with North Dakota state lawmakers and regulators to ensure patient-centered medical homes are physician-led.

10/03/13 (Council) Motion approved that NDMA file an amicus curiae brief in a North Dakota Supreme Court case involving mandating on-label drug use in certain circumstances.

2/17/13 (Executive Council) Motion approved to oppose all abortion bills in the 2013 legislative session because the extent of the interference with the patient physician relationship.

1/29/13 (Council) Motion approved that NDMA oppose SB 2302, the effect which would make IVF illegal, and because of the interference with the patient-physician relationship.

(2012 HOD) Adopted a resolution that NDMA will work with other organizations to oppose legislation or state or federal rules or regulations that interfere with the patient-physician relationship or that prevent physicians from freely discussing with, or providing information to, patients about medical care and procedures, or which direct physicians to provide specified information or perform specified tests that are not medically necessary.

(2009 HOD) Adopted resolution urging the interim ND Legislative Council Health and Human Services Committee to consider expanding supportive services for pregnant minors and consider physician views on their experience implementing the new law [NDCC 14-10-19] on minor consent for pregnancy testing, prenatal care and pain management.

(2008 HOD) Adopted as preliminary 2009 state legislative agenda: Support re-introduction of informed consent for minors' pregnancy-related care (SB 2394).

(2008 HOD) Adopted general policy position relating to the following state legislation: Support the independent medical judgment of physicians in medical practice.

(2006 HOD) Supported the reintroduction of legislation allowing a minor to provide consent for medical treatment related to pregnancy-related care.

(2005 HOD) Reaffirmed support for legislation authorizing minor consent for pregnancy-related care.

(2004 HOD) Adopted a resolution urging NDMA to support state legislation that eliminates the requirement that informed consent for HIV testing be in writing, which was referred for study.

(2004 HOD) Adopted a resolution urging NDMA to support legislation introduced in the 2005 North Dakota Legislative Assembly to provide authorization for a minor to consent for pregnancy-related care.

(2004 HOD) Supported revisions to North Dakota's "Intractable Pain Act" in NDCC Chapter 19-03.3 to clarify definitions and exceptions in the pain management statutes (Commission on Ethics).

(2003 HOD) Based on 2002 House Resolution 5, supported continued implementation of Health Department rules that remove the 48-hour rule for signing or initialing telephone or verbal orders.

(2002 HOD) Resolved that the Association work with the necessary sources to develop appropriate educational sessions to enable physicians to update the emergency response skills they may need if called upon to provide patient care during terrorism (biologic and chemical weapons) and hazardous materials emergencies.

(2002 HOD) Urged the ND Department of Health to amend NDAC 33-07-01.1-20 to remove the 48-hour requirement for signing or initialing telephone and verbal orders.

(2001 HOD) Indicated NDMA's support for the *Matters of Life and Death* project to improve end-of-life care; commended Dr. Clayton Jensen for his work as Project Investigator; and encouraged North Dakota physicians to participate in CME opportunities relating to end-of-life care.

(2001 HOD) Called for a study of North Dakota state and local policies and protocols on "do not resuscitate" orders, including protocols used by emergency medical personnel in out-of-hospital settings.

Prescription Drugs
(2013 HOD) North Dakota Medical Association work with the North Dakota Board of Pharmacy and other stakeholders, to establish a "real-time" reporting of prescriptions and establish and interoperability with EHRs currently used by physicians, both in North Dakota and nationally; and oppose requiring physicians to check the PDMP each time they prescribe a controlled substance and, instead, NDMA will seek to work with the ND Board of Medical Examiners and the North Dakota Board of Pharmacy in order to develop evidence-based guidelines for the appropriate use of the PDMP by prescribers; and NDMA supports physicians who prescribe controlled substances registering with the PDMP and NDMA will encourage the ND Board of Medical Examiners to

facilitate the process of enrolment of prescribers in the PDMP at the time of license renewal; and that NDMA continue its strong endorsement of the PDMP and encourage all physicians to utilize it within their practices; and that NDMA explore the legal issues of participating in the PDMP and educate members on how the PDMP can be used in compliance with current privacy laws.

1/25/07 (Council) Supported bill implementing Prescription Drug Monitoring Program (SB 2134).

1/25/07 (Council) Supported bill to establish a prescription drug and device donation repository program (HB 1256).

4/4/06, 9/14/06, 11/30/06 (Council) Adopted motions opposing any Workforce Safety and Insurance (WSI) prior authorization or prohibition of “dispense as written” prescriptions.

(2006 HOD) Supported a resolution calling for delayed implementation of the ND Prescription Drug Monitoring Program until assurances from the Attorney General are received, or legislative provisions are adopted, providing appropriate protection from liability for physicians.

(2006 HOD) Supported efforts to address issues related to cancer in North Dakota through the actions developed in the North Dakota State Cancer Plan 2006-2010.

(2006 HOD) Encouraged the ND Pharmacy Association to urge North Dakota pharmacies to stock Plan B in their pharmacies as a behind the counter medication for women 18 and older.

(2005 HOD) Adopted a resolution urging the North Dakota Department of Human Services to follow various principles in implementing a North Dakota prescription drug monitoring program that achieves the balanced goals of providing adequate pain management and preventing diversion and abuse of prescription controlled substances.

(2001on NDMA to seek legislation to prohibit pharmacies from releasing physician prescribing pattern information to pharmaceutical companies.
9/21/00 (Council) Motion carried to propose to the NDMA House of Delegates a proposal relating to the addition of the CLIA-waived prothrombin time (4922) test to the list of laboratory tests which may be jointly added by the North Dakota Board of Pharmacy and the North Dakota State Board of Medical Examiners pursuant to NDCC sections 43-15-25.2 and 43-15-25.3, subject to conditions.

(2000 HOD) Resolved that NDMA urge the pharmacy profession that whenever brand name medications are dispensed, the generic name is plainly written in parentheses beneath the brand name, and that the issue be pursued in the House of Delegates of the American Medical Association.

(2000 HOD) Resolved adoption of the Council proposal (above) to address a request by the ND Board of Medical Examiners with respect to Prothrombin Time testing by pharmacists.

Public Health
(2013 HOD) resolution adopted for NDMA support legislative action to raise North Dakota’s cigarette tax to a minimum of $2.00 per pack and all other tobacco products by a proportional amount.

(2012 HOD) Adopted a resolution that that the North Dakota Medical Association support a law in North Dakota to make all workplaces 100% smokefree to protect the health and safety of all workers, residents and visitors from the dangers of secondhand smoke.

(2011 HOD) adopted a resolution that NDMA pursue payment for support the payment for alcohol detoxification treatment in the state of North Dakota through a tax imposed on alcoholic beverages through support of both federal and state legislation and/or other policy advocacy.

1/25/11 (Council) Support bill to establish graduated drivers license concepts for young drivers (HB 1256).

1/25/11 (Council) Support bill to establish concussion management program in youth athletics. Preference for physician to authorize return to play. (SB 2281)

(2009 HOD) Adopted resolution supporting the comprehensive tobacco plan "Saving Lives, Saving Money: North Dakota's Comprehensive State Plan to Prevent and Reduce Tobacco Use," and the essential goals of decreasing the number of people who start using tobacco products, increasing the number of tobacco users who quit, and eliminating exposure to secondhand smoke; and supporting the ongoing tobacco prevention and control efforts and funding of Measure 3.

1/27/09 (Council) Supported bill to expand smoke-free workplace law to bars and hotels/motels (HB 1213); support bill establishing a comprehensive tobacco prevention and control program (SB 2063); and support bill revising the state's coroner laws (SB 2168).

(2008 HOD) Adopted general policy positions relating to the following state legislation: "Support public health initiatives."

(2008 HOD) Supported Initiated Measure 3 for CDC-Based Tobacco Prevention and Cessation Program.

(2007 HOD) Adopted a resolution urging NDMA to support access to and encourage HPV vaccine immunizations.

1/25/07 (Council) Adopted general policy positions relating to the following state legislation: "Support public health initiatives."

1/25/07 (Council) Supported bill to prohibit the sale of small bottle rockets (HB 1389).

1/25/07 (Council) Supported bill to authorize the primary enforcement of the state's seat belt law (HB 1254).

(2006 HOD) Supported further enactment of limitations on smoking in public places, expanding upon the clean indoor air legislation enacted by the 2005 Legislative Assembly.

(2006 HOD) Supported a resolution calling for review of potential means to increase the awareness of the medical consequences of osteoporosis.

(2005 HOD) Continued action based on 2001 and 2002 House resolutions on tobacco control issues, including support for local tobacco control efforts. NDMA has taken the following policy positions on tobacco issues:

1. Support a significant increase in the ND excise tax on tobacco products, and dedicate a substantial portion of the proceeds to a CDC-based tobacco prevention and cessation program.
2. Support increases in state funding for a CDC-based tobacco prevention and cessation program, including changes to the current state program to ensure it is consistent with best practices employed successfully in other states.
3. Ensure that the current local control to implement clean indoor air laws is not preempted by state law.
4. Support any efforts to strengthen state laws pertaining to the restriction of smoking in public places.

5. Encourage the Governor, all ND state legislators and legislative candidates, and other policy makers to actively support funding of tobacco prevention and cessation programs with tobacco settlement revenues, tobacco excise tax revenues, as well as general fund revenues.

(2004 HOD) Continued action based on 2001 and 2002 House resolutions on tobacco control issues, including support for local tobacco control efforts. NDMA has taken the following policy positions on tobacco issues:

1. Support a significant increase in the ND excise tax on tobacco products, and dedicate a substantial portion of the proceeds to a CDC-based tobacco prevention and cessation program.
2. Support increases in state funding for a CDC-based tobacco prevention and cessation program, including changes to the current state program to ensure it is consistent with best practices employed successfully in other states.
3. Ensure that the current local control to implement clean indoor air laws is not preempted by state law.
4. Support any efforts to strengthen state laws pertaining to the restriction of smoking in public places.
5. Encourage the Governor, all ND state legislators and legislative candidates, and other policy makers to actively support funding of tobacco prevention and cessation programs with tobacco settlement revenues, tobacco excise tax revenues, as well as general fund revenues.

(2004 HOD) Continue advocacy on tobacco control issues consistent with previous NDMA policy as measures are introduced in the 2005 session.

(2003 HOD) Continue action based on 2001 and 2002 House resolutions on tobacco control issues, including support for local tobacco control efforts.

(2002 HOD) Expressed strong support for appropriate legislative efforts by the Attorney General and law enforcement agencies during the 2003 Legislative Assembly to address the availability and security of materials and ingredients used to manufacture methamphetamines, including anhydrous ammonia and pseudoephedrine.

(2002 HOD) Supported the concept of universal hearing screenings for all newborns and infants born in ND.

(2002 HOD) Adopted recommendations NDMA-led coalition strategic planning session regarding tobacco issues. The tobacco issues included these steps to reduce the use of tobacco products in ND:

1. Support a significant increase in the ND excise tax on tobacco products, and dedicate a substantial portion of the proceeds to a CDC-based tobacco prevention and cessation program.
2. Support increases in state funding for a CDC-based tobacco prevention and cessation program, including changes to the current state program to ensure it is consistent with best practices employed successfully in other states.
3. Ensure that the current local control to implement clean indoor air laws is not preempted by state law.
4. Support any efforts to strengthen state laws pertaining to the restriction of smoking in public places.
5. Encourage the Governor, all ND state legislators and legislative candidates, and other policy makers to actively support funding of tobacco prevention and cessation programs with tobacco settlement revenues, tobacco excise tax revenues, as well as general fund revenues.

9/20/01 (Council) Motion carried to recommend to expand a resolution before the NDMA House of Delegates to encourage and support local tobacco control efforts.

9/20/01 (Council) Motion carried that the Council recommend to the House of Delegates that the Council review North Dakota's plan for responding to bioterrorism and other terrorist activity, how the plans propose to involve local communities and individual physicians, and take appropriate action.

5/17/01 (Council) Motion carried that the NDMA's Commission on Medical Services and Public Relations provide oversight in NDMA's participation as lead organization for North Dakota in implementing the Smokeless States grant proposal.

(2001 HOD) Supported advocacy for further tobacco use prevention and reduction efforts including use of one-third of the tobacco settlement funds for tobacco use prevention, cessation, and education efforts; and directed the Council to consider NDMA matching funds for the North Dakota Smokeless States effort.

(2000 HOD) Resolved that the NDMA strongly support a statewide, comprehensive, science-based approach to tobacco use prevention and cessation in North Dakota, and develop and support legislation for introduction in the 2001 Legislative Assembly which would assure that fully one-third of future tobacco settlement funds coming to North Dakota be utilized for tobacco use prevention, cessation, and education programs.

(2000 HOD) Resolved that the NDMA support the current state policy of the North Dakota Department of Health in providing metabolic food benefits, and that the Association oppose any legislative or administrative efforts to diminish those benefits.

(2000 HOD) Resolved that the NDMA support private and public programs and strategies for promoting, financing, implementing, and evaluating newborn hearing screening in North Dakota.

(2000 HOD) Pursue legislation defining the role of the physician advisory committee to a non-physician, state health officer, and requiring formal public health credentials for a non-physician state health officer.

Quality
(2007 HOD) Supported participation by NDMA in a partnership with North Dakota Health Care Review, Inc. and the ND Healthcare Association on quality and patient safety initiatives.

4/24/07 (Council) Adopted motion to include NDMA, along with the North Dakota Healthcare Association and North Dakota Health Care Review, Inc., in a partnership to be certified as a "node" for the Institute for Healthcare Improvement "5 Million Lives Campaign."

8/24/05 (Council) Endorsed ND Health Care Review, Inc. in its contract bid as the Quality Improvement Organization for North Dakota.

(2005 HOD) Confirmed support for North Dakota Health Care Review, Inc. as the state's CMS-designated quality improvement organization in its re-contracting bid.

9/30/04 (Council) Adopted motion to express concerns to the CMS Administrator relative to having outside entities serve as subcontractors for portion of work performed by Quality Improvement Organizations (QIOs).

Scope of Practice
(2012 HOD) resolution urging NDMA to support state regulation of nurse midwives and lay midwives; and take appropriate advocacy action that best serves the interests of North Dakota patients.

(2011 HOD) A resolution urging NDMA to advocate all health care professionals, physicians and non-physicians, should be required to accurately and clearly disclose their training and qualifications to patients.

1/25/11 (Council) Oppose bill removing collaborative prescriptive agreement for nurse practitioners (SB 2148)

1/25/11 (Council) Oppose bill allowing licensed addiction counselors to perform mental evaluations in commitment proceedings (SB2040).

1/25/11 (Council) Oppose bill creating a licensing mechanism for naturopaths; use of term "naturopathic physician;" and prescriptive authority for naturopaths (SB 2271).

1/27/09 (Council) Oppose bill allowing psychologists to prescribe psychotropic medications (HB 1488).

(2008 HOD) Adopted general policy position relating to the following state legislation: Support physician scope of practice and oppose inappropriate challenges to that scope of practice / Support revisions to the Medical Practice Act to address scope of practice by mid-levels.

1/25/07 (Council) Adopted general policy position relating to state legislation: "Support physician scope of practice and oppose challenges to that scope of practice." Agreed to monitor closely NDPERS legislation on collaborative drug therapy and diabetes management for pharmacists (HB 1432; HB 1433).

1/25/07 (Council) Supported bill to authorize employment of optometrists by physicians, hospitals and clinics (HB 1123)

1/25/07 (Council) Supported bill to ensure BOMEX oversight of fluoride varnish application by physicians rather than Board of Dentistry (HB 1293).

(2004 HOD) Supported legislation that ensures that only qualified surgeons are allowed to perform eye surgery in VA hospitals (HR 3473).

(2004 HOD) Continued opposition to the Governor's action in exercising opt-out authority that eliminates physician supervision of CRNAs.

(2004 HOD) Continue working with the medical assistant task force and the ND Board of Medical Examiners to define the role of medical assistants while continuing to focus on appropriate legislative proposals that address issues raised by the Attorney General's opinion on the scope of practice of medical assistants. The ND Board of Nursing should be included in discussions regarding the resolution of this issue.

12/18/03 (Council) Motion carried that a letter be sent to the Governor in response to his action to opt out of the CRNA federal physician supervision requirement, which response includes reference to NDMA's ongoing commitment to convince the Governor to reconsider his action.

(2003 HOD) Continued opposition to the Governor exercising opt-out authority that would eliminate physician supervision of CRNAs.

8/12/02 (Council) Motion carried that NDMA oppose the proposed North Dakota Board of Medical Examiners rule lifting the prohibition on physician assistant practice and that the Board be urged to reconsider its previous action in tentatively supporting the proposed rule in light of NDMA's written comments.

(2002 HOD) Opposed the ND Board of Medical Examiner's proposed rule to remove the current prohibition against physician assistants practicing in more than three locations.

(2002 HOD) Opposed to the Governor exercising opt-out authority that would eliminate physician supervision of CRNAs.

12/19/01 (Council) Motion carried that NDMA oppose any efforts to encourage the Governor to exercise the "opt-out" authority that would eliminate physician supervision of CRNAs.

(2001 HOD) Adopted a resolution calling for a study of trends in PharmD scope of practice.

(2000 HOD) Pursue a mechanism for addressing scope of practice issues before the legislative session.

Workforce Safety & Insurance
1/25/11 (Council) Oppose bill to publicly profile physicians who treat injured workers (HB 1052).

1/25/11 (Council) Oppose bill to require that brand name drugs be paid at the generic rate (HB 2053).

1/25/11 (Council) Oppose bill establishing burdensome requirements on physicians treating injured workers for pain (HB 1054).

1/25/11 (Council) Support bill to implement the AMA 6th Edition, rather than the current 5th Edition of the AMA Guides to the Evaluation of Permanent Impairment (HB 1055).

(2009 HOD) Adopted resolution urging the 2011 North Dakota Legislative Assembly to amend the workers compensation statutes to afford workers compensation coverage to workers with preexisting and degenerative conditions.

1/27/09 (Council) Support bill to create a presumption in favor of the treating physician in WSI matters (HB 1561).

(2008 HOD) Adopted resolution urging Workforce Safety & Insurance to continue work on improving the physician fee schedule by developing a more appropriate rebase of the fee schedule comparable to the commercial market in the region, and on improving the WSI relationship with the North Dakota Medical Association and physicians.

(2007 HOD) Adopted a resolution urging Workforce Safety & Insurance to fully recognize the importance of their partner physicians, clinics and hospitals in ensuring continued access to quality medical care for injured workers, to develop a physician payment system that equitably pays for medical services to injured workers in a manner consistent with the commercial insurance market, and to consider the use of WSI surplus reserves to support a more equitable physician payment system. WSI was also urged to consider the use of WSI surplus reserves to support a more equitable physician payment system.

4/4/06, 9/14/06, 11/30/06 (Council) Adopted motions opposing any Workforce Safety and Insurance (WSI) prior authorization or prohibition of "dispense as written" prescriptions.

(2006 HOD) Urged Workforce Safety & Insurance to develop a physician reimbursement system that pays for medical services to injured workers in a manner consistent with the commercial insurance market.

(2003 HOD) Adopted recommendation that NDMA support the concept of working together with ND Workforce Safety and Insurance (workers compensation) to implement a second level appeals process involving binding dispute resolution to address denied claims.

Report of the President

One year has passed since we have met as a body of physicians to look after the business of the North Dakota Medical Association. Our Association has had a busy and interesting year.

Legislative activity usually dominates the news and interest of your association. 2014 was not a legislative year but legislative affairs still dominate our activities. Anyone who has heard me talk about the Medical Association has heard me emphasize the conversations in which we engage as health care policy is formulated. As legislation is formulated the NDMA is engaged with legislative and administrative entities and our voice and interests usually are a consideration as the legislative session approaches.

A number of issues will need to be followed and our Executive Director, Courtney Koebele, will detail those at our meeting and keep us up to date as the legislative session approaches and progresses.

I have had the opportunity to represent the NDMA at the AMA. The annual meeting meets in June in Chicago and this year's interim meeting was in Washington DC in November. Courtney Koebele and I also attended the AMA advocacy meeting in Washington in March.

It is fascinating that issues of concern to North Dakota's physicians are not unique, and the AMA commonly is addressing issues we are addressing. As an example, our last House of Delegates passed a resolution to look into protection of physicians' online reputation and this is an issue being addressed at the AMA.

The big emphasis as we spent some time on advocacy issues on Capitol Hill is addressing the problem physicians have with our badly flawed compensation system, the SGR. There was great hope that it would be corrected during this congressional session but the Republican House passed a correction acceptable to physicians but attached it to a repeal of the Affordable Care Act, which was a non-starter in the Senate. Hope has been revived and there is an ongoing push to see a correction during the lame duck congress so that we do not need to start over.

The North Central Medical Conference meets three times a year, at the two AMA meetings and in Minneapolis in March. This is an association of the medical associations of North Dakota, South Dakota, Minnesota, Iowa, Nebraska, and Wisconsin. Spending time with our neighbors in medicine is very useful as our populations, medical system, and patients are very similar, and therefore our conversations are productive.

Our executive director, Courtney Koebele, and I have had the opportunity to attend several district medical Society meetings around the state. It is a joy to spend some time driving our beautiful state to have the opportunity to visit with physicians and health care administrators around the state. We have been to Valley City, Bismarck, Dickinson, Minot, Williston, and of course I get to the district meeting in Fargo regularly. If we haven't been to see you at your home community to attend your medical association meeting we welcome an invitation.

Two issues have consumed a lot of our resources this last year. As you look at your handbook, in the vice-president's report you will notice that we have had a drop in membership. One of our large physician employers who have in the past provided membership for each of their physicians has decided to not continue that policy. They will pay for membership for every physician who wishes to be a member but we have needed to approach physicians individually and solicit membership. It has been a rewarding experience in that we have been given the opportunity to be somewhat introspective to assess our value to physicians so that we can honestly ask for membership but as the number show, not all physicians choose to join. I think we have been to our nadir and we will build our membership number back up.

Membership revenue does pay our bills so we have had to budget carefully. What you have most likely noticed is that all of our communication is now electronic. We did remove printing and mailing from our budget.

The other issue is personhood. I will always emphasize that NDMA does not have a position on abortion. None of our deliberations of the personhood amendment have considered abortion.

We do have concerns that this amendment may have real impact on the relationship we have with our patients, particularly when managing end of life care, complicated pregnancy, and our infertility patients with assisted fertility techniques.

The North Dakota Medical Association is one of the smallest in the country. Our office staff is correspondingly small but an incredible and effective advocacy for physicians and our patients exists in the office in Bismarck. My thanks, on your behalf to Courtney, Katie, Leann, and Annette. No better quartette work anywhere.

Drs. Geier, Nammour and Anderson are bright, talented, dedicated physicians, which assures NDMA's leadership into the future. Past Presidents Orser, Beattie, Krohn, and Booth continue active and contributing roles. They display a dedication to continued service that is beyond reasonable for us to ask.

I want to thank the physicians of North Dakota for the great privilege of serving as the president of NDMA.

Respectfully submitted,
Steven P. Strinden, MD
NDMA President

Report of the Vice President and Council Chair

Council Members

Officers

Steven P Strinden, MD, President
Debra A Geier, MD, Vice President and Council Chair
Fadel E Nammour, MD, Secretary-Treasurer
Misty K Anderson, DO, Speaker of the House
A Michael Booth, MD, Immediate Past President
Robert W Beattie, MD, AMA Delegate
Shari L Orser, MD, AMA Alternate Delegate

Councillors

First District
Neville M Alberto, MD
Stephanie K Dahl, MD
Harjinder K Virdee, MD
Second District
Vacancy
Third District
Randolph E Szlabick, MD
Rory D Trottier, MD
Fourth District
Steven R Mattson, MD
Fifth District
Misty K Anderson, DO
Sixth District
Shelly A Seifert, MD
Vacancy
Seventh District
Sarah L Schatz, MD
Eighth District
Joseph E Adducci, MD
Ninth District
Dennis E Wolf, MD
Tenth District
Timothy J Luithle, MD
Eleventh District
Catherine E Houle, MD

Commission and PAC Chairs

Ethics
Kristina A Schlecht, MD
Legislation and Governmental Relations
Sarah L Schatz, MD
Medical Education
Kimberly T Krohn, MD
Medical Services and Public Relations
Shari L Orser, MD
Socio-Economics
Parag Kumar, MD
PAC
Thomas I Strinden, MD

The NDMA Council is the executive body charged with managing the property and financial affairs of the Association and responsible for implementing the policy decisions of the House of Delegates, the supervision of staff, and the finances of the Association. NDMA's bylaws give the Council the full authority and power of the House of Delegates between meetings of House of Delegates, and confer authority on the executive committee to manage the business of the Association as necessary between meetings of the Council, and perform other functions as assigned by the Council as well.

In carrying out its responsibilities, the Council worked to implement various resolutions adopted by the House of Delegates, approved an operating budget for 2014, participated in discussing NDMA's approach to addressing issues in the 2013-2014 Interim ND Legislative Session and addressed many other policy issues. This report highlights the major activities of the Council, Commissions and other NDMA functions. Since the 2013 NDMA annual meeting, the Council meetings were held December 10, 2013, January 14, 2014, March 1, 2014, May 27, 2014, July 29, 2014, and August 19, 2014.

A special thanks to all our Councillors and officers for their dedicated service to the medical profession in our state and to our NDMA members who chair and serve on NDMA commissions, our NDMA PAC Board and those who have agreed to serve on the various state agency boards and committees as representatives on our behalf.

Member Benefits

DocBook, MD – NDMA continues its agreement with Docbook, MD, an exclusive HIPAA-secure messaging application for smartphone and tablet devices. Designed by and for physicians it creates a secure community to share patient information and collaborate with medical colleagues. Docbook is currently offered in 37 states across over 200 state and county medical societies. This is an exclusive member benefit.

Wisconsin Medical Journal – NDMA continues its partnership with the Wisconsin Medical Journal. NDMA members receive complimentary copies of the journal for a year, with unlimited online access to WMJ. WMJ provides a forum for publishing scientific research, case reports, review articles and other writings that inform and educate the medical community. Each journal offers 1 CME credit. Through this partnership, NDMA members are invited to submit a manuscript or brief report, to serve as a reviewer, or simply to become a reader and take advantage of the CME available. There are also opportunities for NDMA members to serve on the editorial Board.

Oakstone Publishing – NDMA continues its agreement with Oakstone publishing to offer discounted CME to members through three different websites: CME info which offers these programs to help prepare for certification and re-certification exams; Practical Reviews, which offers provides subscribers access to peer-reviewed clinical research that is compiled and summarized with commentary from leading experts across 29 specialties; and Personal Best, which offers discounted rates for monthly publications, brochures, posters, trackers, and kits for patient & community education and marketing.

CDL- Medical Examiner Training – in response to the new federal requirement that medical examiners for CDL licenses be certified, NDMA partnered with the Montana Medical Association and Essential Education Network to become a registered NRCME training provider for medical professionals seeking to be listed on the National Registry website. NDMA's online training course is designed to meet the core curriculum requirements for medical examiners according to the Federal Motor Carrier Safety Administration (FMCSA). This training course was extremely popular with many types of medical providers and provided revenue to NDMA.

NDMA Policy Advocacy

Policy Comments – NDMA develops comments to proposed rules and participates with other physician organizations in providing comments on issues. NDMA signed on to comment letters with national specialty and state medical societies and the American Medical Association regarding the following issues:

> *Veterans Health Affairs Handbook (10/28/13)* - As organizations representing the majority of the nation's physicians, we write to express our strong concerns regarding the draft Veterans Health Affairs (VHA) Handbook 1180.03: VHA Nursing Handbook, which would mandate that all advanced practice nurses (APRNs) within the VHA be designated as independent providers, without regard to state practice acts. We are concerned that some of the changes proposed may significantly undermine the delivery of care within the VHA while disregarding the states' role in regulating the health and safety of their residents in the delivery of health care services.
>
> *Sunshine Act – Journal Articles reportable (10/28/13)* - The undersigned physician organizations representing both national medical societies and state medical societies are writing to express our serious concerns about the Center for Medicare and Medicaid Services' (CMS) recently promulgated regulations to the Sunshine Act and their impact on scientific peer reviewed medical journals and textbooks. We believe the regulations in this regard are contrary to both the statute and congressional intent and will potentially harm patient care by impeding ongoing efforts to improve the quality of care through timely medical education.

Medicare Advantage Program (11/7/13) - On behalf of the undersigned physician organizations, we urge the Centers for Medicare & Medicaid Services (CMS) to take immediate action to ensure that Medicare beneficiaries participating in Medicare Advantage (MA) plans have accurate and reliable information to make health insurance elections during the 2014 Open Enrollment period, and to address a lack of MA sponsor transparency on network adequacy. The American Medical Association (AMA) and a number of state medical associations and national medical specialty societies have been contacted by hundreds of physicians indicating that they have been terminated from 2014 MA plan networks of UnitedHealthcare (United) and other insurers in select markets. The terminations are "without cause" and have been timed in a manner that undermines the accuracy and reliability of the information Medicare beneficiaries are relying upon in order to make important health care decisions for 2014 health insurance coverage. The timing and process used to communicate the terminations and modifications to the networks are not consistent with CMS guidance and regulations.

SGR Repeal and Reform (2/7/14 and 3/5/14) - The undersigned state medical societies and national specialty organizations congratulate House and Senate negotiators on the introduction of H.R. 4015/ S. 2000, the SGR Repeal and Medicare Provider Payment Modernization Act of 2014. Now, Congress is closer than it has ever been to enacting fiscally-prudent legislation that would repeal Medicare's fatally flawed sustainable growth rate (SGR) formula. It is critically important to build on this work and maintain the momentum.

Medicare Appeals Backlog (2/12/14) - On behalf of the undersigned organizations, we write to you to express serious concern about the backlog of Medicare appeals. We are particularly troubled by the recent notice by the Office of Medicare Hearings and Appeals (OMHA) that assignment of requests for Administrative Law Judge (ALJ) hearings may be delayed for up to 28 months. We are also discouraged that OMHA still predicts that, even after this delay, post-assignment hearing wait times are likely to continue to exceed six months. While we understand and appreciate that OMHA has convened a forum today to discuss the backlog of Medicare appeals, we are concerned that this forum alone will not sufficiently address the multitude of issues that patients and physicians face when the Medicare appeals process is not working properly. We therefore strongly urge OMHA to develop a comprehensive solution to the Medicare appeal backlog problem so that appealed cases may be assigned and adjudicated without delay.

90 Day Grace Period under the ACA (3/5/14) - The undersigned medical organizations respectfully request that the Centers for Medicare & Medicaid Services (CMS) revisit its policy that allows health insurers who offer qualified health plans on the exchanges (issuers) to pend and deny claims for months two and three of the 90-day grace period. We further urge CMS to strengthen the requirements for how and when issuers notify physicians and other providers that a patient who has purchased subsidized Affordable Care Act (ACA) exchange health insurance coverage has entered the 90-day grace period for non-payment of premiums. Specifically, we recommend that CMS require issuers to provide grace period information as soon as a patient enters the first month of the grace period.

Medicare Hospital Conditions of Participation (7/1/14) - The undersigned organizations write to express our extreme disappointment with the Centers for Medicare & Medicaid Services (CMS) final rule entitled Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Part II [CMS-3267-F]. This rule makes unprecedented changes to the Medicare hospital Conditions of Participation (CoPs) that will dramatically alter the make-up and efficacy of hospital medical staffs nationwide.

As we evaluate the lawfulness of CMS' significant new regulatory actions, revisions, and interpretations in this final rule, we strongly urge CMS to delay the effective date of July 11, 2014. We understand that in a recent letter to the American Medical Association (AMA), CMS declined to delay the effective date of its revisions to the medical staff CoP. We strongly disagree with this decision and urge CMS to reconsider. This

date does not allow adequate time for CMS to clarify its ruling nor for medical staffs to be educated about the major ramifications of the rule and duly amend their bylaws.

Sunshine Act – Implementation (7/30/14) - The undersigned medical associations and medical specialty societies are writing to register serious concerns with implementation of the Physician Payments Sunshine Act (Sunshine Act) and to request an expanded timeframe to allow recipients to register, review, and dispute their data in the Open Payments System before publication. Our organizations represent physicians who are directly impacted as covered recipients in the Open Payments System or indirectly impacted through their affiliation with teaching hospitals. Many of our organizations supported passage of the Sunshine Act and, fundamentally, we have no issue with efforts to increase transparency in the interactions between physicians and industry. However, we have a number of serious concerns regarding how the Open Payments System has been implemented.

Implementation of 2013 Resolutions

The 2013 Annual Meeting of the House of Delegates resulted in the adoption of several resolutions and other action requiring implementation by the Council and NDMA staff. The implementation activities associated with each resolution or House action are summarized below.

Resolution No. 1 – Gun Safety: This resolution resolved that the North Dakota Medical Association urge our Congressional Delegation to work with Congress to repeal the existing ban on firearm related research and provide sufficient resources to study firearm related injury data; and NDMA encourage the development and presentation of gun safety programs that educate the public on the responsible use and storage of firearms; and that NDMA submit a resolution to the next AMA House of Delegates, if not already under consideration, to repeal the ban on federally sponsored research on gun violence.

The AMA modified their policy right after the NDMA annual meeting:

H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior. (Sub. Res. 221, A-13; Appended: Res. 416, A-14).

Resolution No. 2 – PDMP: this resolved that the North Dakota Medical Association work with the North Dakota Board of Pharmacy and other stakeholders, to establish a "real-time" reporting of prescriptions and establish and interoperability with EHRs currently used by physicians. The resolution further resolved that NDMA will seek to work with the ND Board of Medical Examiners and the North Dakota Board of Pharmacy in order to develop evidence-based guidelines for the appropriate use of the PDMP by prescribers; and finally resolved that NDMA

will encourage the ND Board of Medical Examiners to facilitate the process of enrolment of prescribers in the PDMP at the time of license renewal.

NDMA staff and President Steve Strinden have been working diligently on this issue. Both Executive Director Courtney Koebele and communications director Katie Fitzsimmons are members of the Keeping Narcotics out of Our Communities task force. The committee has been meeting regularly for the past year. A sub-group of the committee has been working on PDMP interoperability and discussions held regarding linking the PDMP to medical license. The PDMP is "almost" in real time at this point, and is interoperable with the NDHIN and EPIC systems. NDMA continues to work with the Board of Pharmacy and the Board of Medical Examiners to allow signing up for the PDMP to be linked to medical licensing system. NDBOMEX is in the process of drafting administrative rules for evidence-based guidelines for use of the PDMP. NDMA has had considerable input into those rules.

<u>Resolution No. 3 – Repeal of IPAB</u>: This resolution resolved that NDMA would urge congress to repeal IPAB.

NDMA has had policy discussions with our congressional issues about this issue as part of the SGR discussion.

<u>Resolution No. 4 – Disrespect and Derogatory Conduct</u>: This resolved that NDMA work with appropriate organizations to encourage the adoption of uniform guidelines for physicians to follow in non-life threatening emergencies when they encounter patients who verbally abuse practitioners because of the physician's race, ethnicity, or other personal characteristic. The House of Delegates referred this issue to the Commission on Ethics.

The Commission on Ethics has reviewed the issue and has re-drafted the resolution for the 2014 House of Delegates.

<u>Resolution No. 5 – Physician Led Team-Based Care</u>: NDMA is to advocate for physician led team –based care.

Although the issue was not raised in the interim, it is likely to become an issue in the 2015 legislative session. NDMA will continue to pursue opportunities to emphasize this important issue.

<u>Resolution No. 6 – Raising ND Tobacco Tax</u>: this resolution provided that NDMA support legislative action to raise North Dakota's cigarette tax to a minimum of $2.00 per pack and all other tobacco products by a proportional amount. NDMA has joined the Raise-it Coalition to increase the tobacco tax, and the committee has been meeting regularly.

NDMA will support the issue during the 2015 legislative session.

<u>Resolution No. 7 – Health Website Ratings</u>: this resolution was referred to the Commission on Socioeconomics. The commission met to review the issue and had recommendations for staff to implement.

The issue is also on the agenda for the 2014 annual meeting, with a CME presentation on the issue of health website ratings and protecting physician reputation.

NDMA will continue to seek opportunities both within the legislative session and within the community to promote these policies.

<u>ND Legislature</u>

<u>SCR 4009: Measure 1 on the 2014 November Ballot</u>

To solidify the North Dakota Medical Association's reputation as a scientific body, the decision was made to not support either advocacy group on Measure 1. After discussion with the Council and the Commission on Legislation, NDMA decided to offer information about both positions in order for members to make an informed decision on their personal vote.

Interim Committees

Health Care Reform Review Committee

The Health Care Reform Interim committee, chaired by Representative George Keiser, has met seven times in the past year. Two significant bills have been approved for recommendation to Legislative Management. The first is a telemedicine bill to provide health insurance parity in health insurance coverage of telemedicine. Telemedicine is a rapidly developing method of delivering health care. Policy makers are interested because the possibility of increasing access to all North Dakotans, but particularly those in rural areas. The bill draft was revised to provide the mandate of coverage be limited to the Public Employees Retirement System (PERS) uniform group insurance plan for the first two years, to direct PERS to study the impact of the bill during that two-year period, and to direct PERS to introduce at the 2017 legislative session a bill to extend the mandate of coverage to the private market. The second bill increases the role an advanced practice registered nurse may play in involuntary commitment proceedings by adding advanced practice registered nurses to the defined terms "expert examiner" and "independent expert examiner" as well as adding advanced practice registered nurses to those provisions in the chapter which authorize physicians to act. The bill is drafted with the goal of expanding the role advanced practice registered nurses may play in the involuntary commitment proceedings but not expanding the scope of practice established by the State Board of Nursing. NDMA is supportive of this bill, but is watching carefully so that providers are practicing within their scope of practice.

Human Services Committee

The interim North Dakota Human Services Committee, chaired by Representative Chuck Damschen, is looking at one of the most prominent issues facing the state and health care in general: behavioral health. In the 2013 session, Senate Bill 2243 (2013), provided for a Legislative Management study of behavioral health needs. The study was required to include consideration of behavioral health needs of youth and adults, and the scope of the study included consideration of access, availability, and delivery of services. The Human Services Committee was assigned responsibility for this study for the 2013-14 interim. The Chairman of the Legislative Management authorized the committee to spend up to $45,000 for the consulting services. On January 7, 2014, the committee voted to hire Schulte consulting. Ms. Renee Schulte, principal, is a former Iowa legislator and mental health professional and prides herself on building trust and respect among groups from differing backgrounds and perspectives.

Schulte also identified low-cost/high-impact strategies to improve behavioral health services which may require statutory changes include amending North Dakota Century Code Section 25-03.2-01 to change the definition of a "qualified mental health professional" to include professionals with a master's degree in a behavioral health field or practitioners with a bachelor's degree in a behavioral health field and experience; and create a new section of Century Code to identify professional licensing reciprocity requirements.

The committee met on August 28 and reviewed bill drafts related to the establishment of an oversight system and reciprocity language for behavioral health licensing boards; the definition of qualified mental health professional; and appropriations for adult and youth substance abuse services, ePsychiatry equipment for critical access hospitals, telemedicine equipment for the human service centers and federally qualified health centers, and mental health first-aid training for law enforcement.

Health Services Committee

The Health Services Committee, chaired by Senator Judy Lee, met five times throughout the interim. The committee has been studying a number of issues, including Community Paramedics, Comprehensive Statewide Tobacco Prevention and Control, and Dental Services and autopsy funding, to name just a few. NDMA will be monitoring this committee with regard to developing legislation.

Workers Compensation Review Committee
The Workers Compensation Review committee, chaired by Senator Lonnie Laffen, will be meeting on September 8, 2014, and reviewing a WSI independent performance evaluation that was conducted during this interim on the following items:
1. Independent medical evaluations (IMEs), including a review and documentation of the entire IME process; including determining the total costs made to IME physicians and other third parties related to IMEs; reviewing and documenting the process WSI follows to recruit IME physicians and determining if WSI is following relevant state statutes; and determining the percentage of times the IMEs were conducted by North Dakota physicians
2. Fraud investigations, including a review and documentation of the processes WSI uses to detect and investigate employer fraud, employee fraud, and medical provider fraud
3. Claims, including evaluating the appeals process available to claimants
4. Vocational rehabilitation, including determining if WSI has sufficient policies and procedures established to guide the staff and to establish protocol to ensure consistent, quality services for the return-to-work injured employees

Two bills have been discussed as a result of the evaluation – one affecting treatment of WSI claimants with opioids, and one with PTSD. NDMA continues to monitor and testify as to these issues affecting North Dakota physicians.

NDHIN

The NDHIN advisory committee is charged with making recommendations for implementing a statewide interoperable health information infrastructure that is consistent with emerging national standards and promotes interoperability of health information systems for the purpose of improving health care quality, patient safety, and overall efficiency of health care and public health services.

NDMA's executive director, Courtney Koebele is a member of the North Dakota Health Information Network (NDHIN) advisory committee. She, along with many NDMA members, is also a member of the clinical advisory workgroup and the legal and policy workgroup.

State Agencies

NDMA is involved on an ongoing basis with issues raised in the context of state agencies, including the ND Board of Medical Examiners, Health Department, Department of Human Services, Insurance Department and Workforce Safety & Insurance.

NDMA Commissions

Commission on Legislation – This Commission has a new chair, Sarah Schatz, MD, and is starting to develop an agenda for NDMA for the 2015 ND Legislative Assembly, focusing on opioid prescribing issues, Medicaid payment issues, behavioral health and other issues. See the separate report of the Commission on Legislation.

Commission on Ethics – This Commission has a new chair, Kristina Schlecht, MD, is exploring POLST (Physician-Ordered Life-Sustaining Treatment) and the newly formed advanced care directive group, Honoring Choices, ND. The commission reviewed the derogatory conduct resolution from 2013 HOD and has submitted an amended resolution for 2014 HOD. See the separate report of the Commission on Ethics.

Commission on Medical Services – This Commission, chaired by Shari Orser, MD met to review the nominations for the NDMA Physician Community and Professional Services Award; and the NDMA Friend of Medicine Award.

Commission on Socio-Economics – This Commission, chaired by Parag Kumar, MD, met to review the resolution on online ratings/reputation referred to it by 2013 HOD.

NDMA PAC

Special thanks for the work Tom Strinden does as chair of our NDMA Political Action Committee. *Your PAC is Important!*

To be a player in policymaking, our profession must continually build relationships with individual state legislators and legislative leadership, as well as our Congressional Delegation, the Governor and other elected officials. NDMA PAC is an important part of our advocacy efforts. NDMA member physicians and NDMA Alliance members, medical students and resident members are eligible to join NDMA PAC.

Under the NDMA PAC operation guidelines, each district medical society may appoint one physician member and each district alliance society may appoint one nonphysician member to the board. The operating guidelines do not set specific terms. Districts are asked to review their representation and make any necessary changes. The NDMA staff has developed a question and answer information sheet that addresses the most commonly addressed questions about NDMA PAC and AMPAC. The question and answer brochure provides answers to commonly asked questions such as how an individual contribution can be directed to a particular candidate.

One of the important functions of the NDMA PAC Board is to determine which candidates should receive support. Board members also serve as the political leader for organized medicine in each district and can be instrumental in recruitment and in facilitating discussions between candidates and physicians in each district. NDMA PAC is not bound by party ties, but contributes to candidates who appreciate the work physicians do and the environment we work in.

The NDMA PAC Board will meet on October 8, 2014, to determine contributions to candidates for the current election cycle. As of September 27, 2014, PAC membership is 34 members with contributions of $7,295 (AMPAC $3,647.50 and NDMA PAC $3.647.50).

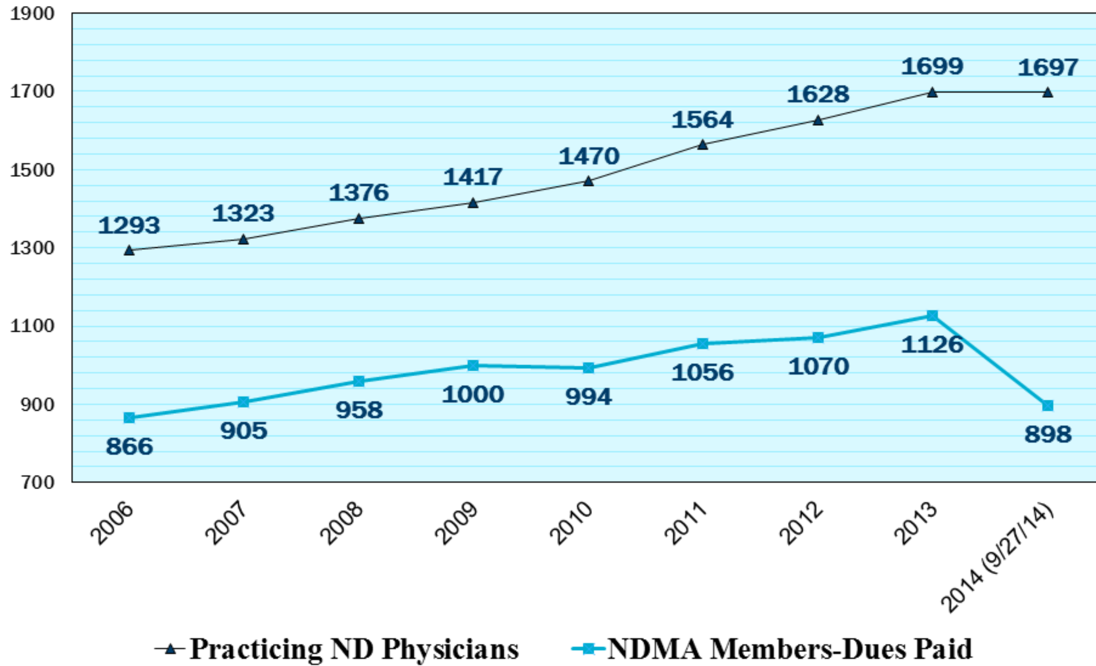
A thank you is extended to all current NDMA PAC members. Joining NDMA PAC at the Annual Meeting is an excellent way to remember your annual membership.

NDMA Membership

Current NDMA Membership Trends – The physician members of NDMA are the backbone to successful Association advocacy. NDMA exceeded its membership goal of 1045 members in 2013 with 1126 paid members.

For 2014, the NDMA budget goal is 937 regular active members. The projected decrease in regular active membership is due to change in Sanford Health North's membership dues payment policy. Instead of the standard opt-out program, it switched to an opt-in program in late 2013. NDMA was able to work with Sanford Health on this change and retain many members but NDMA continues to feel the effect. We are optimistic about what this policy will look like in the future and how NDMA will be able to recruit and retain members.

NDMA membership is at 898 paid regular active members as of September 27, 2014. We typically garner additional members as the year progresses who pay half or quarter-year dues. However, there are still many physicians in North Dakota who do not participate in providing the resources necessary for successful advocacy, yet still benefit from the work NDMA does. About 793 regular active physicians in North Dakota are not NDMA members. The chart below depicts our membership status over time:



Regular active membership by district, depicted in this chart:

2014 Dues

North Dakota Medical Association Regular Active Membership Report By District as of 9-27-14

District	Number of Regular Active Physicians	Number of RE Members	RE Member Dues Received	RE Member Dues Outstanding	RE Member %	Number of RE Non-Members	RE Non-Member %
1	686	407	388	19	59.3%	279	40.7%
2	43	18	17	1	41.9%	25	58.1%
3	252	199	193	6	79.0%	53	21.0%
4	157	14	14	0	8.9%	143	91.1%
5	9	6	6	0	66.7%	3	33.3%
6	416	188	179	9	45.2%	228	54.8%
7	26	17	17	0	65.4%	9	34.6%
8	45	22	21	1	48.9%	23	51.1%
9	43	17	16	1	39.5%	26	60.5%
10	5	4	4	0	80.0%	1	20.0%
11	15	12	11	1	80.0%	3	20.0%
Total	1697	904	* 866	38	53.3%	793	46.7%

***Does not include the 32 physicians that retired or left the state.**

NDMA Financial Information

2014 Operating Budget – NDMA continues to achieve a level of fiscal stability, primarily through regular active membership, non-dues revenue generated by administrative and lobbying arrangements, grants for special projects, some publications revenue, and an endorsement arrangement with the Midwest Medical Insurance Company. Expenses are continuously scrutinized and reduced where possible. Nevertheless, the NDMA budget is inherently a year-by-year proposition, based heavily on dues income. In previous budgets, NDMA has maintained the following budgetary guidelines:

- Non-dues revenue goal of approximately 50% of annual revenue, through administrative and lobbying arrangements with state specialty societies and other financial opportunities.
- Maintenance of reserves constituting six-months of NDMA operating expenditures. As understood (although NDMA has no written policy), the primary purpose of these funds is to provide contingency funds, representing accumulated surpluses that are used only for purposes designated by the Council or House of Delegates. The discussion has identified these funds as long-term (five to ten years) in nature and income and any capital gains are generally retained and reinvested within the reserve fund. No specific short or long-term uses for these funds have been identified.
- Balanced budget.

While a $31,537 year-end balance was projected for 2013, the actual year-end balance in 2013 came in at $30,388. NDMA reserves are currently at an amount equal to about five months operating expenses.

The Council approved a 2014 budget with salary adjustments with a projected ending balance of $4,550.

Respectfully submitted,
Debra A. Geier, MD
Vice President and Council Chair

Report of the Secretary-Treasurer

2013 North Dakota Medical Association Membership

*Member Type	Total Physicians in NDMA Database	Total Number of NDMA Members in Database	%That Are Members	Non-Members	%That Are Non-Members	2013 Dues Received	% of Members that have Paid 2013 Dues	2013 Goal	% Attainment of Goal
Regular Active	**1699	***1105	65.0%	594	35.0%	****1126	101.9%	*****1045	107.8%
Residents	109	56	51.4%	53	48.6%	40	71.4%	58	69.0%
Life	183	183	100.0%	N/A	N/A	N/A	N/A	N/A	N/A

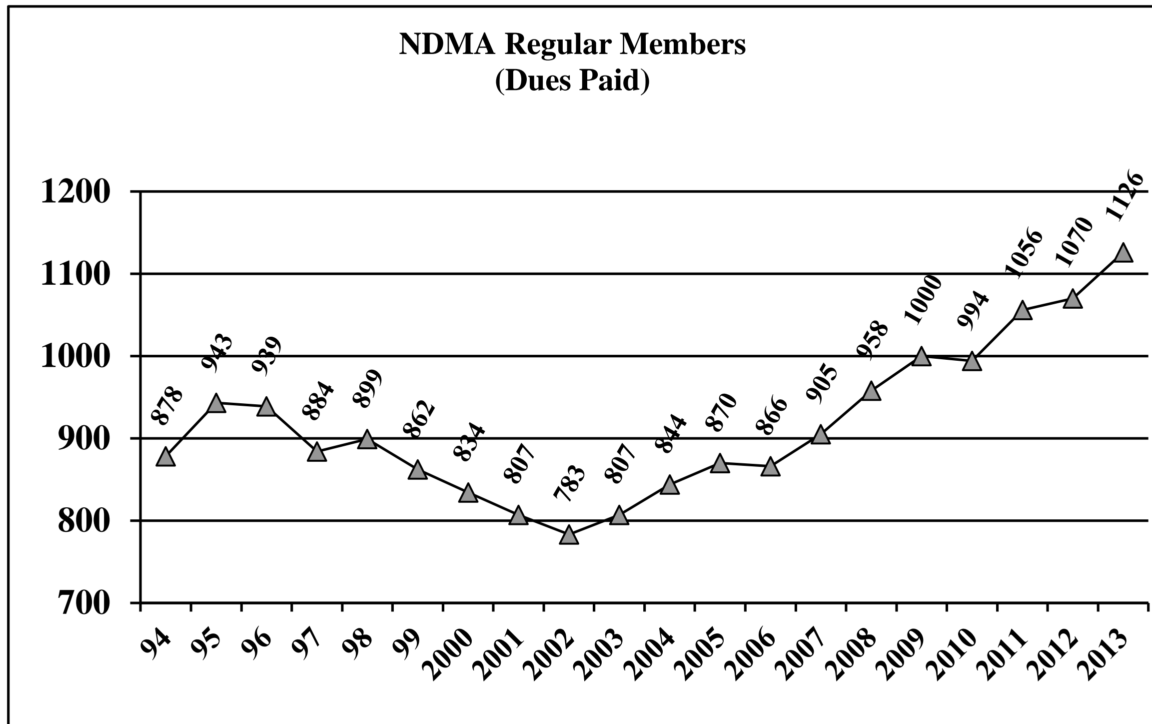
*Member type when dues are received - member status may change.
**1680 reside in ND + 19 (that are members) outside of ND
***34 entered in database toward year end that were not be billed for 2013 dues.
****Includes dues received from 41 regular active physician that have left the state and 14 that have retired.
*****Goal: 1015 @ $450, 30 @ $225
Actual dues received: 1047 @ $450, 9 @ $338, 49 @ $225, 1 @$150, & 20 @ $113

2013 North Dakota Medical Association Regular Active Membership by District

District	Number of Regular Active Physicians	Number of RE Members	RE Member Dues Received	RE Member Dues Outstanding	RE Member %	Number of RE Non-Members	RE Non-Member %
1	685	581	571	10	84.8%	104	15.2%
2	47	21	20	1	44.7%	26	55.3%
3	258	206	198	8	79.8%	52	20.2%
4	164	19	18	1	11.6%	145	88.4%
5	9	8	8	0	88.9%	1	11.1%
6	405	195	194	1	48.1%	210	51.9%
7	26	18	18	0	69.2%	8	30.8%
8	48	23	11	12	47.9%	25	52.1%
9	36	17	17	0	47.2%	19	52.8%
10	5	4	4	0	80.0%	1	20.0%
11	16	13	12	1	81.3%	3	18.8%
Total	1699	1105	*1071	**34	65.0%	594	35.0%

*Does not include the 41 regular active physicians that have left the state and the 14 that retired.
*34 entered in database toward year end that were not billed for 2013 dues.

NDMA Regular Members 1994-2013 Comparison



NDMA Membership 2012-2013 Comparison

Category	Number of Physicians in NDMA Database 2012	Number of Physicians in NDMA Database 2013	Change	2012 Paid Members	2013 Paid Members	Change	% 2012 Paid Members of Total Physician	% 2013 Paid Members of Total Physician
Regular Active	1648	1699	51	1070	1126	56	64.93%	66.27%
Residents	109	109	0	56	40	-16	51.38%	36.70%
Life	178	183	5					

2012/2013 AMA Comparison Report Federation and Direct Members as of 1/3/14

Category	2012 Direct	2013 Direct	Direct Change	2012 Federation	2013 Federation	Federation Change	2012 Total	2013 Total	2012/2013 Change
Physician	180	186	6	177	140	-37	357	326	-31
Resident	46	97	51	28	16	-12	74	113	39
Student	8	9	1	289	296	7	297	305	8
	234	292	58	494	452	-42	728	744	16

New 2013 Regular Active Members

Edward L Adams MD, Grand Forks
Ryan J Agema MD, Fargo
Mohammed M Alam MD, East Grand Forks
Minhal H Alhashim MD, Grand Forks
Noor Azreen Ali MD, Minot
Albert P Allick MD, Fargo
Oksana I Anand MD, Fargo
Samuel O Anim MD, Fargo
Gregory G Ausmus MD, Fargo
Mohamad K Baaj MD, Minot
Varsha Babu MD, Fargo
Ramesis Bacolod MD, Grand Forks
Amanda J Beehler DO, Fargo
Peter Biegler III MD, Fargo
Zhanyong Bing MD, Fargo
Michael J Blankinship MD, Fargo
Jill M Briggs MD, Fargo
Maximo O Brito MD, Fargo
Anthony N Brown MD, Fargo
Michael Ray Brown MD, Bismarck
Jeremy F Brudevold DO, Fargo
Melanie M Brumwell MD, Fargo
Sree Budati MD, Grand Forks
Joni L Buechler Price MD, Fargo
Brad R Buell MD, Fargo
Jantey Carey MD, Fargo
Kari A Casas MD, Fargo
Luis Casas MD, Fargo
Chris L Cleveland MD, Fargo
Manuel Colon-DeJesus MD, Fargo
Christopher DeCock MD, Fargo
Stephanie M Delvo MD, Bismarck
Khalin F Dendy MD, Bismarck
Taylor F Dowsley MD, Fargo
Cornelius M Dyke MD, Fargo
Kwame D Eagleton MD, Grand Forks
Andrea M Eickenbrock MD, Grand Forks
Rachel M Fleissner MD, Fargo
Stephanie Foughty MD, Grand Forks
Christopher S Fukuda MD, Bismarck
Kristina L Garrels MD, Fargo
Karyssa A Gibbs MD, Fargo
Randolph D Gibbs MD, Fargo
Steven K Glunberg MD, Detroit Lakes
Alicia A Glynn MD, Fargo
Vikesh Gupta MD, Bismarck
Nader Habli MD, Fargo
Nathaniel L Hall MD, Fargo
Samy Heshmat MD, Fargo
April A Hess MD, Fargo
Nicholas A Hoskins MD, Bismarck
Sara N Houston MD, Fargo
Chris Irmen MD, Grand Forks
Adam W Jackson MD, Fargo
Diosdado T Jaramillo MD, Bismarck
Kara J Johnson MD, Fargo
Katherine Joseph MD, Grand Forks
Prakash Kafle MD, Fargo
James G Kappenman MD, Fargo
Samantha S Kapphahn DO, Fargo
Jeffrey R Keim MD, Fargo
SM Farhan Khan-Galzie MD, Fargo
Robyn Knutson Bueling MD, Fargo
Bradley W Kohoutek MD, Fargo
Karol Z Kremens MD, Fargo
Corey J Kroetsch MD, Fargo
Paulina J Kunecka MD, Fargo
Mark Larkins MD, Grand Forks
Joshua LeClaire DO, Fargo
Collette R Lessard-Anderson MD, Grand Forks
Hung Kei Li MD, Fargo
Aaron L Luebke MD, Bismarck
Jay M MacGregor MD, Fargo
Sathyanarayana M Machani MD, Fargo
Sanju Mahato MD, Minot
Devendranath R Mannuru MD, Fargo
Kristine E Martens DO, Fargo
Saif A Mashaqi MD, Fargo
Clifford T Mauriello MD, Fargo
Denise M McDonough MD, Mandan
Matthew J McLeod MD, West Fargo
Michael A Mirzai MD, Bismarck
Ramesh Mishra MD, Grand Forks
Monika Moni MD, Minot
Prashant Morolia MD, Minot
Jennifer L Mullally MD, Fargo
Eugeniu V Muntean MD, Fargo
Avish Nagpal MD, Fargo
Brook V Nelson MD, Dickinson
Jeffrey J Nelson MD, Bismarck
Rebecca K Novacek MD, Grand Forks
Prince Pannu MD, Minot
Shahmohammed F Parves MD, Fargo
Mahesh Patel MD, Bismarck
Navin Paul MD, Fargo
Hong Q Peng MD, Fargo

New 2013 Regular Active Members Continued

Jedidiah J Perkerewicz MD, Fargo
Maritza Proano MD, Fargo
Elena R Raducu MD, Bismarck
Carrie Ann Ranum MD, Hettinger
Karim B Rashid MD, Fargo
Garett A Rhule MD, Williston
Heather L Rusten DO, Grand Forks
Joyoti Saha MD, Fargo
Ravinda Samaraweera MD, Fargo
Prasad J Sawardeker MD, Fargo
Subhechchha Shah MD, Grand Forks
Rafiyath Shamudheen MD, Fargo
Kamille S Sherman MD, Grand Forks
Eric Siegel MD, Fargo
Tanya L Skager MD, Dickinson
Vitaliy Starosta MD, Fargo
Christina M Tello Skjerseth MD, Bismarck
Priyanka Tiwari MD, Fargo
Sumit Tiwari MD, Fargo
Todd Twogood MD, Bismarck
Peter Van Eerden MD, Fargo
Diane Voeller MD, Grand Forks
Matthew L Voigt MD, Bismarck
Elmer R Wasemiller MD, Wahpeton
Matthew E Wiisanen MD, Fargo
Andrew J Wilder MD, Bismarck
William F Wosick MD, Fargo
Rebecca M Ziegler MD, Fargo

In Memoriam

Galen J Eash, MD
Fargo, ND
9/2/1939 – 3/16/2014

Martha E Glower, MD
Fargo, ND
11/5/1963 – 12/17/2013

Anthony B Gustafson, MD
Fargo, ND
9/6/1945 – 6/11/2014

Gerald J Kavanaugh, MD
Fargo, ND
12/5/1927 – 3/1/2014

M Jerome Olson, MD
Williston, ND
8/24/1934 – 4/6/2014

Presidents of the North Dakota Medical Association

Years	Name	Site of Practice	Years	Name	Site of Practice
1887-1890	J.G. Millspaugh, MD	Park River	1948-1949	W.A. Liebeler, MD	Grand Forks
1890-1891	Henry W. Coe, MD	Mandan	1949-1950	Willard A. Wright, MD	Williston
1891-1892	William C. Sherlock, MD	Fargo	1950-1951	Leonard W. Larson, MD	Bismarck
1892-1893	Albert P. Rounsevell, MD	Larimore	1951-1952	W.E.G. Lancaster, MD	Fargo
1893-1894	Isaac N. Wear, MD	Fargo	1952-1953	Olafur W. Johnson, MD	Rugby
1894-1895	Albert B. Herrick, MD	Lisbon	1953-1954	Joseph Sorkness, MD	Jamestown
1895-1896	Henry M. Wheeler,MD	Grand Forks	1954-1955	Philip H. Woutat, MD	Grand Forks
1896-1897	James P. Aylen, MD	Fargo	1955-1956	David J. Halliday, MD	Kenmare
1897-1898	August Eggers, MD	Grand Forks	1956-1957	Reuben H. Waldschmidt, MD	Bismarck
1898-1899	Francis R. Smyth,MD	Bismarck	1957-1958	Reginald W. Rodgers, MD	Dickinson
1899-1900	George F. Bates,MD	Hillsboro	1958-1959	Oliver A. Sedlak, MD	Fargo
1900-1901	Hezekiah J. Rowe, MD	Casselton	1959-1960	John C. Fawcett, MD	Devils Lake
1901-1902	Harry D. Quarry, MD	Grand Forks	1960-1961	Carroll M. Lund, MD	Williston
1902-1903	George A. Carpenter, MD	Fargo	1961-1962	Edwin H. Boerth, MD	Bismarck
1903-1904	W.H. Bodenstab, MD	Bismarck	1962-1963	Ernest J. Larson, MD	Jamestown
1904-1905	J.A. Rankin, MD	Bismarck	1963-1964	Amos R. Gilsdorf, MD	Dickinson
1905-1906	Paul Sorkness, MD	Fargo	1964-1965	G. Alfred Dodds, MD	Fargo
1906-1907	Robert D. Campbell, MD	Grand Forks	1965-1966	Joseph D. Craven, MD	Williston
1907-1908	Charles MacLachian, MD	New Rockford	1966-1967	Glenn W. Toomey, MD	Devils Lake
1908-1909	Henry A. Beaudoux, MD	Fargo	1967-1968	Verrill J. Fischer, MD	Minot
1909-1910	John E. Countryman, MD	Grafton	1968-1969	Clifford H. Peters, MD	Bismarck
1910-1911	Henry H. Healy, MD	Grand Forks	1969-1970	Robert C. Painter, MD	Grand Forks
1911-1912	C.E. Spicer, MD	Valley City	1970-1971	Thomas E. Pederson, MD	Jamestown
1912-1913	Alex J. McCannel, MD	Minot	1971-1972	Frank A. DeCesare, MD	Fargo
1913-1914	Murdock MacGregor, MD	Fargo	1972-1973	William M. Buckingham, MD	Bismarck
1914-1915	Richard H. Beek, MD	Lakota	1973-1974	Dean R. Strinden, MD	Williston
1915-1916	Victor H. Stickney, MD	Dickinson	1974-1975	Phillip O. Dahl, MD	Bismarck
1916-1917	Victor J. LaRose, MD	Bismarck	1975-1976	Richard S. Larson, MD	Velva
1917-1918	George M. Williamson, MD	Grand Forks	1976-1977	Robert W. McLean, MD	Hillsboro
1918-1919	Edgar A. Pray, MD	Valley City	1977-1978	Robert J. Ulmer, MD	Fargo
1919-1920	William P. Baldwin, MD	Casselton	1978-1979	Harold W. Evans, MD	Grand Forks
1920-1921	Fred E. Ewing, MD	Kenmare	1979-1980	James J. Moses, MD	Bismarck
1921-1922	Harley E. French, MD	Grand Forks	1980-1981	Clifford J. Klein, MD	Valley City
1922-1923	Eric P. Quain, MD	Bismarck	1981-1982	O. Victor Lindelow, MD	Bismarck
1923-1924	James Grassick, MD	Grand Forks	1982-1983	D. Ross Halliday, MD	Fargo
1924-1925	W.C. Fawcett, MD	Starkweather	1983-1984	William T. Powers, MD	Grand Forks
1925-1926	John H. Rindlaub, MD	Fargo	1984-1985	Dennis E. Wolf, MD	Dickinson
1926-1927	Niles O. Ramstad, MD	Bismarck	1985-1986	Paul J. Beithon, MD	Wahpeton
1927-1928	Thomas Mulligan, MD	Grand Forks	1986-1987	M. Jerome Olson, MD	Williston
1928-1929	William F. Sihler, MD	Devils Lake	1987-1988	Donald F. Barcome, MD	Grand Forks
1929-1930	John Crawford, MD	New Rockford	1988-1989	Robert L. Geston, MD	West Fargo
1930-1931	Andrew Carr, MD	Minot	1989-1990	Albert F. Samuelson, MD	Bismarck
1931-1932	Henry M. Waldren, Sr., MD	Drayton	1990-1991	Daniel W. Goodwin, MD	Grand Forks
1932-1933	Paul H. Burton, MD	Fargo	1991-1992	Raman A. Patel, MD	Tioga
1933-1934	Jesse W. Bowen,Sr., MD	Dickinson	1992-1993	Glenn M. Thoreson, MD	Mayville
1934-1935	Clyde E. Stackhouse, MD	Bismarck	1993-1994	Ben J. Clayburgh, MD	Grand Forks
1935-1936	Archibald D. McCannel, MD	Minot	1994-1995	Steven K. Hamar, MD	Bismarck
1936-1937	William A. Gerrish, MD	Jamestown	1995-1996	Wallace E. Radtke, MD	Fargo
1937-1938	Edwin L. Goss, MD	Carrington	1996-1997	Robert E. Grossman, MD	Hettinger
1938-1939	William H. Long, MD	Fargo	1997-1998	Jacob Kerbeshian, MD	Grand Forks
1939-1940	Harry A. Brandes, MD	Bismarck	1998-2000	Matthew D. Layman, MD	Bismarck
1940-1941	Cyril J. Glaspel, MD	Grafton	2000-2002	Kathleen A. Wood, MD	Grand Forks
1941-1942	F.W. Fergusson, MD	Kulm	2002-2003	Russel J. Kuzel, MD	Fargo
1942-1943	Alfred R. Sorenson, MD	Minot	2003-2005	Robert W. Beattie, MD	Hettinger
1943-1944	Frank I. Darrow, MD	Fargo	2005-2007	Shari L. Orser, MD	Bismarck
1944-1945	F.L. Wicks, MD	Valley City	2007-2009	Robert A. Thompson, MD	Grand Forks
1945-1946	James F. Hanna, MD	Fargo	2009-2011	Kimberly T. Krohn, MD	Minot
1946-1947	Albert F. Spear, MD	Dickinson	2011-2013	A. Michael Booth, MD	Bismarck
1947-1948	Philip G. Arzt, MD	Jamestown	2013-	Steven P. Strinden, MD	Fargo

North Dakota Medical Association
Physician Community and Professional Services Award Recipients

Paul J. Beithon, MD	Wahpeton	1977
Nelson A. Youngs, MD	Grand Forks	1978
Richard S. Larson, MD	Velva	1979
Robert W. McLean, MD	Hillsboro	1980
James H. Mahoney, MD	Devils Lake	1981
Phillip O. Dahl, MD	Bismarck	1982
Melvin S. Jacobson, MD	Elgin	1982
Dean R. Strinden, MD	Williston	1983
Robert C. Painter, MD	Grand Forks	1984
Edward J. Hagan, MD	Williston	1985
William R. Fox, MD	Rugby	1986
William C. Riecke, MD	Bismarck	1987
Robert B. Tudor, MD	Bismarck	1988
George M. Johnson, MD	Fargo	1989
Keith G. Foster, MD	Bismarck	1990
Robert L. Geston, MD	West Fargo	1991
John W. Goven, MD	Valley City	1992
Herbert J. Wilson, MD	New Town	1993
Lee A. Christopherson Sr, MD	Fargo	1994
Mack V. Traynor, MD	Fargo	1995
Raman A. Patel, MD	Tioga	1996
Dennis E. Wolf, MD	Dickinson	1997
Clifford J. Klein, MD	Valley City	1998
Ralph L. Kilzer, MD	Bismarck	1999
Raymond S. Gruby, MD	Bismarck	2000
John L. Crary, MD	Fargo	2001
Marlin JE Johnson, MD	Bismarck	2002
Rupkumar Nagala, MD	Oakes	2003
Steven K. Hamar, MD	Bismarck	2004
Clayton E. Jensen, MD	Valley City	2005
Glenn M. Thoreson, MD	Mayville	2006
Bruce G. Pitts, MD	Fargo	2007
Bernard J. Hoggarth, MD	Grand Forks	2008
Timothy J. Mahoney, MD	Fargo	2009
Robert R. Tight, MD	Fargo	2010
James D. Brosseau, MD	Grand Forks	2011
Vani Nagala, MD	Oakes	2012
John M. Leitch, MD	Fargo	2013

North Dakota Medical Association
Friend of Medicine Award Recipients

Sen. Judy DeMers	Grand Forks	1999
Rep. Rick Berg	Fargo	1999
Rep. Wanda Rose	Bismarck	1999
Sr. Michael Emond, PA-C	Hettinger	2000
Sherlyn Dahl	Fargo	2001
Kelly Schmidt	Minot	2002
Mary Muhlbradt	Minot	2002
Vern Hedland	Valley City	2003
Evan Lips, Sr.	Bismarck	2004
Thomas Clifford	Grand Forks	2004
Robert E Peabody	East Grand Forks	2005
Carol Meidinger	Bismarck	2006
Kent Brackel	Hettinger	2007
Congressman Earl Pomeroy	Bismarck	2008
J. Patrick Traynor	Fargo	2009
Senator Byron Dorgan	Bismarck	2010
Bruce T. Levi	Bismarck	2011
Senator Kent Conrad	Bismarck	2012
Dan Kelly	Watford City	2013

2014 Forty Year Certificates of Appreciation

Davis L Bronson MD, Bismarck
Norman T Byers MD, Grand Forks
William D Canham MD, Bismarck
Ajitkumar S Damle MD, Tampa, FL
Stanley T Diede MD, Bismarck
Paul J T Fetterly MD, Devils Lake
Walter E Frank MD, Bismarck
Steven K Hamar MD, Bismarck
Bernard J Hoggarth MD, Grand Forks
Richard E Johnson MD, Devils Lake
Stephen A Korte MD, Bismarck
Timothy J Mahoney MD, Fargo
Richard J Marsden MD, Fargo
Nicholas H Neumann MD, Bismarck
Russell W Petty MD, Cando
Gregory J Post MD, Detroit Lakes, MN
Philip S Sedo MD, Crosby, ND
Bradford A Selland MD, Fargo
James W Vanlooy MD, Eagle, ID
Allen E Wyman MD, Minot

Balance Sheet as of December 31, 2013

	Dec 31, 13
ASSETS	
Current Assets	
Checking/Savings	
1000 · Cash In Bank	73,425.50
1020 · Wells Fargo Advisors	377,197.85
Total Checking/Savings	450,623.35
Other Current Assets	
1499 · Undeposited Funds	641.28
Total Other Current Assets	641.28
Total Current Assets	451,264.63
TOTAL ASSETS	**451,264.63**
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Credit Cards	
2050 · Credit Card	1,691.15
Total Credit Cards	1,691.15
Other Current Liabilities	
1941 · Unearned Income-Dues	158,519.00
2100 · Payroll Liabilities	1,024.00
2111 · Direct Deposit Liabilities	2,589.73
2500 · A/P Dues	840.00
Total Other Current Liabilities	162,972.73
Total Current Liabilities	164,663.88
Total Liabilities	164,663.88
Equity	
3000 · Opening Bal Equity 1/1/96	107,442.35
3010 · Change in Value of Investments	-22,155.45
3900 · Retained Earnings since 1/1/96	170,926.06
Net Income	30,387.79
Total Equity	286,600.75
TOTAL LIABILITIES & EQUITY	**451,264.63**

2013 Profit and Loss Budget vs. Actual

	Jan - Dec 13	Budget	$ Over Budget	% of Budget
Ordinary Income/Expense				
Income				
4000 · Membership Dues	490,228.00	464,950.00	25,278.00	105.44%
4010 · Interest	2,985.47	2,000.00	985.47	149.27%
4020 · Commission on AMA Dues	1,271.43	1,700.00	-428.57	74.79%
4060 · Sales	13,736.65	60,000.00	-46,263.35	22.89%
4070 · Advertising	4,250.00	10,000.00	-5,750.00	42.5%
4075 · Annual Meeting	2,750.00	3,000.00	-250.00	91.67%
4080 · Administrative Services Income	35,600.00	35,600.00	0.00	100.0%
4095 · Legislative Monitoring	300.00	2,000.00	-1,700.00	15.0%
4115 · MMIC Royalty	50,000.00	50,000.00	0.00	100.0%
4180 · Grants	7,150.00	7,150.00	0.00	100.0%
4230 · Miscellaneous Income	194.06			
Total Income	**608,465.61**	**636,400.00**	**-27,934.39**	**95.61%**
Expense				
6000 · Payroll Expenses	305,948.26	304,747.00	1,201.26	100.39%
6030 · Payroll Taxes	23,047.48	22,950.86	96.62	100.42%
6060 · Medical Insurance	48,206.30	47,761.00	445.30	100.93%
6070 · Retirement	36,713.82	36,569.00	144.82	100.4%
6095 · Employee Health Promotion	1,080.00	1,440.00	-360.00	75.0%
6100 · Travel	40,846.81	52,450.00	-11,603.19	77.88%
6200 · Councils and Commissions	373.77	1,100.00	-726.23	33.98%
6300 · Programs	9,630.30	12,060.00	-2,429.70	79.85%
6400 · Rent	30,852.00	30,852.00	0.00	100.0%
6410 · Insurance-Contents & Liability	1,627.00	1,500.00	127.00	108.47%
6415 · Insurance-Officer Liability	1,864.00	1,815.00	49.00	102.7%
6420 · Furniture & Equipment Purchase	5,000.00	5,000.00	0.00	100.0%
6430 · Dues & Subscriptions	3,094.97	3,600.00	-505.03	85.97%
6435 · Directory	79.10	12,700.00	-12,620.90	0.62%
6440 · Magazine	12,601.96	13,350.00	-748.04	94.4%
6460 · Office Equip Lease & Maintenance	-1,225.49	-500.00	-725.49	245.1%
6470 · Office Supplies & Expenses	4,190.99	7,500.00	-3,309.01	55.88%
6480 · Printing	60.00	1,000.00	-940.00	6.0%
6490 · Postage	2,348.45	3,500.00	-1,151.55	67.1%
6500 · Telephone	6,478.49	5,000.00	1,478.49	129.57%
6600 · Professional Fees	22,222.26	16,878.00	5,344.26	131.66%
6760 · Annual Meeting Expenses	8,150.67	8,000.00	150.67	101.88%
6770 · Advocacy Expenses	2,994.05	5,750.00	-2,755.95	52.07%
6800 · Administrative Services	203.05	1,300.00	-1,096.95	15.62%
6841 · INBRE Grant	4,672.90	40.00	4,632.90	11,682.25%
6860 · Taxes	1,826.00	2,500.00	-674.00	73.04%
8000 · Bank/Investment Charges/Fees	2,687.33	2,300.00	387.33	116.84%
8005 · Credit Card Processing Fees	2,503.35	3,700.00	-1,196.65	67.66%
Total Expense	**578,077.82**	**604,862.86**	**-26,785.04**	**95.57%**
Net Ordinary Income	**30,387.79**	**31,537.14**	**-1,149.35**	**96.36%**
Net Income	**30,387.79**	**31,537.14**	**-1,149.35**	**96.36%**

North Dakota Medical Association 2014 Approved Budget

	Jan - Dec 14
Ordinary Income/Expense	
Income	
4000 · Membership Dues	418,650.00
4010 · Interest	2,000.00
4020 · Commission on AMA Dues	1,000.00
4060 · Sales	67,000.00
4070 · Advertising	5,000.00
4075 · Annual Meeting	1,800.00
4080 · Administrative Services Income	35,600.00
4115 · MMIC Royalty	50,000.00
4180 · Grants	7,150.00
Total Income	**588,200.00**
Expense	
6000 · Payroll Expenses	319,979.00
6030 · Payroll Taxes	23,909.79
6060 · Medical Insurance	54,092.00
6070 · Retirement	38,397.42
6095 · Employee Health Promotion	1,440.00
6100 · Travel	34,200.00
6200 · Councils, Commissions, T.Forces	650.00
6300 · Programs	9,960.00
6400 · Rent	30,852.00
6410 · Insurance-Contents & Liability	1,700.00
6415 · Insurance-Officer Liability	1,900.00
6420 · Furniture & Equipment Purchase	5,000.00
6430 · Dues & Subscriptions	2,692.00
6435 · Directory	13,700.00
6460 · Office Equip Lease & Maint	-500.00
6470 · Office Supplies & Expenses	5,000.00
6480 · Printing	1,000.00
6490 · Postage	2,500.00
6500 · Telephone	5,000.00
6600 · Professional Fees	12,838.00
6760 · Annual Meeting Expenses	8,000.00
6770 · Advocacy Expenses	1,500.00
6800 · Administrative Services	1,300.00
6841 · INBRE Grant	40.00
6860 · Taxes	2,500.00
8000 · Bank/Investment Charges/Fees	2,700.00
8005 · Credit Card Processing Fees	3,300.00
Total Expense	**583,650.21**
Net Ordinary Income	**4,549.79**
Net Income	**4,549.79**

North Dakota Medical Research Foundation Report

The North Dakota Medical Research Foundation was incorporated in 1966 as a 501(c)(3) tax-exempt organization. The Foundation was originally formed to implement the Regional Medical Program (RMP), a federal program designed to provide grants to states to develop regional cooperative arrangements between institutions and individuals to provide the latest advances in treatment of heart, cancer, stroke, and related diseases. However, the scope of purposes for the Foundation is much broader than the RMP program, which was completed in the seventies.

In 1998 through 2002, the Foundation received grants from the Robert Wood Johnson Foundation (RWJF) under the Foundation's *Community-State Partnerships for Improving End-of-Life Care* program. The *Matters of Life and Death* Project resulting from the grant formed a coalition of over fifty organizations that worked to improve end-of-life care in North Dakota. The grant funding for that project has concluded.

Under the Foundation's bylaws, NDMA's Councillors serve as the Board of Directors of the Foundation. As Foundation Board, the Council is considering options for the future role and structure of the Foundation.

The North Dakota Medical Research Foundation balance as of December 31, 2013 was $21,619.78.

Respectfully submitted,
Fadel E. Nammour, MD
Secretary-Treasurer

2014 Report of the AMA Delegate

2013 Interim Meeting Highlights

The AMA Interim meeting, held in National Harbor, Maryland, November 16-19, 2013, was attended by NDMA President Steve Strinden, MD; NDMA Council Chair and Vice President Debra Geier, MD; NDMA AMA Delegate Robert Beattie, MD; NDMA Alternate Delegate Shari Orser, MD; and NDMA Executive Director Courtney Koebele. The AMA adopted the following policies, among many others, at the meeting:

Recommendations for Payment Models Supporting Team-Based Care
The AMA has been working to provide much-needed guidance on implementation of these models and issued a report outlining recommendations for the development of payment mechanisms that promote satisfaction and sustainability of team-based models in various practice settings. To further aid implementation of these new models, the AMA House of Delegates adopted an additional policy that more specifically defines team based roles and concepts including “physician-led,” “supervision,” and “collaboration.”

Push Against RAC Payment Incentives
The AMA will continue to strongly push back on the contingency fee compensation structure that promotes aggressive overreach among Medicare audit contractors. A new directive adopted calls for penalizing recovery auditors, also known as recovery audit contractors (RACs), when denials resulting from audits are overturned in favor of physicians.

Drug Availability, Abuse and Pain Management
Four new policies deal with the appropriate availability and use of medications. The first policy gives a contemporary review of national drug control policy and calls for a variety of changes, including developing community-based prevention programs for at-risk youth and increasing the accessibility of treatment programs for substance use disorders. A second policy aims to address opioid-associated overdoses and deaths. It directs the AMA to develop a set of best practices to inform clinical use of these drugs in managing persistent pain. It also calls for the Centers for Disease Control and Prevention to collect more robust data on unintentional opioid poisonings and deaths to develop appropriate solutions for preventing such incidences. Another policy asks the Joint Commission to re-evaluate its accreditation standard for pain management; that standard should improve pain management practices. The fourth policy requires the AMA Council on Science and Public Health to give a report evaluating the state of the nation’s drug shortage crisis at each AMA policymaking meeting.

ICD-10
Two policies related to the Oct. 1, 2014 implementation deadline for the ICD-10 code set were adopted. One calls for continued advocacy to delay or cancel implementation, and another asks the AMA to seek federal legislative and regulatory reform to require funding assistance for physician practices to alleviate the financial burden associated with implementation costs, including upgrades and staff training.

Health Insurance Coverage
In response to the many patients who have been notified that their existing insurance plans will be canceled, delegates adopted a policy to support urgent efforts to help patients maintain coverage while facilitating a smooth transition to alternative coverage options.

Expanding FDA Authority over Nicotine Delivery Products
This policy advocates for the U.S. Food and Drug Administration (FDA) to extend its tobacco regulations to include all non-pharmaceutical tobacco and nicotine products, including electronic cigarettes (e-cigarettes), pipes, cigars and hookahs.

Physician Satisfaction
The AMA will study current tools and develop metrics to measure physician satisfaction. Findings from a recent RAND Corporation study sponsored by the AMA show that being able to provide high-quality health care is a primary driver of job satisfaction among physicians, and obstacles to quality patient care are a source of stress for doctors.

While in the Washington, D.C. area, the NDMA group met with Senator Heidi Heitkamp and her staff, Representative Cramer and his staff, and Senator Hoeven's staff to discuss the importance of the SGR repeal and other issues concerning North Dakotan physicians. All of the meetings were productive and beneficial; it is always great to get face time with our accessible and participative elected officials. We were very thankful for their attention, open ears, and flexibility to meet with us. Their commitment to NDMA is not new and we are grateful to maintain good relationships with each of them.

To read more about the meeting and adopted policies, go to:
ama-assn.org/ ama/pub/about-ama/our-people/housedelegates/ meeting-archives/2013-interim meeting.page

2014 Annual Meeting Highlights

A delegation of NDMA leaders attended the American Medical Association (AMA) Annual Meeting of the House of Delegates (HOD) June 7-11 in Chicago. The HOD is the legislative and policymaking body of the AMA, composed of elected representatives and others. AMA alternate delegate Shari Orser, MD, NDMA President Steve Strinden, MD, and NDMA executive director Courtney Koebele joined me at the meeting. Maryland reproductive endocrinologist and OB-GYN Robert M. Wah, MD, assumed the AMA presidency. The 169th president of the AMA, and the first Asian American to hold the post, Dr. Wah emphasized in his inaugural address both the importance of tradition and the courage to embrace change. The AMA adopted the following policies at its House of Delegates meeting in June:

Critical Access Hospitals

Among the new policies adopted by the HOD was a resolution drafted by South Dakota regarding Critical Access Hospitals (CAHs), and joined by North Dakota, Nebraska, Wisconsin and Iowa. President Obama's budget called for cuts to CAHs' Medicare reimbursement and elimination of the designation affording cost-based payment for facilities within 10 miles of any hospital, regardless of whether the nearby hospital is capable of providing the services that would be lost if the CAH closed. These cuts would be detrimental to CAHs throughout the country – impeding their ability to provide high-quality care. CAHs play a vital role in providing access to health care, economic security for families and seniors, and jobs to rural communities across the nation. These hospitals provide inpatient and outpatient services, as well as 24-hour emergency care, and make it possible for patients with complex medical needs to remain at home in rural communities.

The new resolution calls on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks, opposes the elimination of the CAH necessary provider designation, and asks that the federal government fully fund its obligations under the Medicare Rural Hospital Flexibility Program. After a committee referred this issue for further study, South Dakota members spoke against referral at the HOD, and the testimony led to voting against referral and the resolution passed on the HOD floor.

Quicker Care for Veterans

Physicians voted to ask President Obama to provide timely access to entitled care for eligible veterans via the health care sector outside of the VA health care system until the VA can provide health care in a timely fashion. The new AMA policy also directs the AMA to urge Congress to quickly enact long-term solutions so eligible veterans can have timely access to entitled care permanently. The policy came in response to recent access-to-care problems that have left thousands of veterans unable to receive care in a timely fashion.

Telemedicine

The HOD passed a new telemedicine policy that lays out principles for coverage and payment. The HOD approved a set of principles to ensure the appropriate coverage of and payment for telemedicine services. The principles aim to support future innovation in the use of telemedicine while ensuring patient safety, quality of care, and the privacy of patient information, as well as protecting the patient-physician relationship and promoting improved care coordination and communication with medical homes. The policy reiterates the importance of national medical specialty societies continuing to be involved in the development of appropriate and comprehensive practice parameters, standards, and guidelines to address the clinical and technological aspects of

telemedicine. Delegates also called for a study of the issues associated with the state based licensure and the portability of state licensure for telemedicine services.

e-Cigarette Regulation
A new policy was adopted that opposes the sale and marketing of electronic cigarettes and nicotine delivery products to minors. The new policy extends existing policy that calls for all e-cigarettes to be subject to the same regulations and oversight that the Food and Drug Administration applies to tobacco and nicotine products. The use of e-cigarettes by students in U.S. middle schools and high schools more than doubled from 3.3 percent in 2011 to 6.8 percent in 2012, according to the Centers for Disease Control and Prevention.

Electronic Data Interchange
New policies adopted call for changes to health IT. The policies include directing the AMA to work with the federal government and electronic health record (EHR) vendors to establish a process to achieve data exchange. One policy addresses “data lock-in,” in which information stored in one EHR system cannot easily be transferred to another system. Another policy calls for the AMA to engage the EHR vendor community to secure changes to their systems that would better meet physicians’ practice needs.

Respectfully submitted,
Robert W. Beattie, MD
AMA Delegate

Report of the Executive Director

The Executive Director, "with the Council, develops strategic plans to address the changing culture of the healthcare industry; provides relevant association services for the NDMA membership; implements policies and services through professional staff; collaborates with state and national constituents to develop and maintain an innovative problem-solving environment in the best interest of NDMA members; and coordinates and supervises the provision of legal services to the Association and its members."

As the Executive Director of NDMA, it's important for me to continually evaluate with our physician leadership what the Association is doing to support our physician membership. Your NDMA Council has consistently avoided creating benefits and services that do not relate specifically to the NDMA primary roles of leadership in advocacy, ethics and professionalism. A list of membership benefits and services describes the value of NDMA membership:

NDMA Membership Benefits and Services

Participation Opportunities
If you choose to get directly involved in the Association, there are many opportunities for personal and professional development. They include:

- Seeking NDMA leadership positions such as President and Vice President, Speaker of the House, Secretary-Treasurer, or AMA Delegate of Alternate Delegate
- Seeking leadership positions in District Medical Societies, including NDMA Councillor or Delegate to the NDMA House of Delegates
- Participating in NDMA's Annual Meeting and CME Conference
- Participating in other NDMA-sponsored CME
- Participating in the NDMA PAC, or being a key local contact with legislators
- Participating as a member of one of NDMA's Commissions, including Ethics, Socio Economics, Medical Education, Medical Services and Public Relations, and Legislation and Governmental Relations
- Participating in NDMA's Doctor of the Day program during the legislative session
- Assisting NDMA lobbyists by providing legislative testimony
- Seeking nomination by NDMA to the board or commission of a state agency, or other public or private appointment process
- Participating in activities of your District Medical Society and the NDMA Alliance
- Writing an article for NDMA's *ND Physician* publication
- Providing feedback to NDMA's physician leadership on issues that impact your practice
- Simply *being a member* and supporting the work of your NDMA and District Medical Society

Advocacy on Public Policy
Legislation and administrative regulations adopted by the North Dakota Legislative Assembly, the U.S. Congress, and state and federal agencies directly affect how you practice medicine. With your NDMA membership, physician leaders and staff professionals represent you every day.

NDMA provides effective *advocacy and legislative representation for physicians.* Your NDMA membership gives physicians an independent voice on critical issues such as Medicare and Medicaid reform, scope of practice, medical staff self-governance, medical student debt, medical liability reform, coverage for the uninsured, quality improvement, patient safety and public health.

In advocacy before the North Dakota Legislature, NDMA often forges or participates in *strategic alliances with other organizations* to achieve results. Your NDMA physician leadership and staff are actively representing you every day of the legislative session, as well as during the interim between sessions when the ND Legislative Council interim committees undertake a wide variety of studies. These interim studies often result in recommendations for legislation.

NDMA also maintains close contact with the North Dakota *Congressional Delegation and congressional staff* on federal issues that might affect the quality of health care in our state. We work closely with the American Medical Association and national specialty societies to ensure our state efforts are supported by an organized national campaign whenever necessary.

NDMA has also worked to *improve public health and understanding of the medical profession*. NDMA works in collaboration with the state health officer, and in coalitions to improve public health and raise awareness of public health issues throughout the state and in individual communities, including tobacco use, immunizations,

bioterrorism and disaster preparedness, and violence prevention. NDMA advocacy efforts provide a very visible assurance to your patients that physicians care about health policy.

Overall, NDMA's advocacy efforts cross a variety of *public agencies* on regulatory matters, including the State Board of Medical Examiners, Department of Health, Department of Human Services, Workforce Safety and Insurance, Attorney General's Office, Governor's Office, and the Insurance Commissioner / Department. Our staff and officers provide valuable input to these and other agencies throughout the year.

Advocacy in the Private Sector
Commercial insurance company practices, hospital employment practices, medical staff issues, and similar topics concern physicians and are a focal point for NDMA advocacy efforts along with the American Medical Association. NDMA is a state medical society member of the Litigation Center of State Medical Societies and the AMA, which coordinates litigation efforts across the country in cases of interest to physicians. NDMA is actively involved with the AMA Organized Medical Staff Section. NDMA staff also participate in AMA's Private Sector Advocacy activities.

NDMA physician leadership and staff meet regularly with the senior staff of *BlueCross BlueShield of North Dakota* to ensure ongoing communication.

Practice and Legal Information
NDMA staff provides general practice and legal information for physicians and the professionals who serve with them. NDMA staff includes a full-time attorney and a variety of information resources. Staff are available to work with you on issues that impact your practice. NDMA's website at www.ndmed.org, provides information on a variety of topics, and is the Association's primary means of providing current legislative information.

Collegiality and Professionalism
The Association offers the collegiality of physicians working together to provide their peers with valuable resources and support. NDMA's annual meeting, educational opportunities, opportunities for serving on Commissions, and other activities bring physicians together from across the state. NDMA's Commission on Ethics provides the basis for NDMA's support of activities that promote professionalism, including education on professional issues like end-of-life care (EPEC), presentations to medical students, "Ethics Moment" articles in *ND Physician* working to network ethics committees in the state, and providing an ethical perspective on proposed legislation.

Public and Media Relations and Resources for Public Presentations
NDMA handles communications from patients who have concerns about their health care. We protect their interests by helping them find solutions to their problems. At the same time, we provide a service to our members by making recommendations for conflict resolution if necessary.

NDMA serves you well in providing media relations on behalf of the medical profession as a whole, as well as useful information or other resources or advice on topics if you are asked to be interviewed or provide public presentations.

Publications and Communications
Publications include the *ND Physician* which is published electronically three times each year. The newsletter provides timely information of interest to members of the Association. The *North Dakota Medical Services Directory* is a contact directory published annually, and is available for a nominal charge.

NDMA uses online vehicles as the primary mode of communicating with members. The *e-Physician* is periodic e-mail sent to members on matters of importance, including legislative activity. NDMA's website at www.ndmed.org also provides current information and archived materials for your use.

Specialty Society Support
NDMA supports several ND specialty society chapters, through administrative arrangements for staffing, advocacy and office work.

Annual Meeting
The Association, in conjunction with specialty societies, conducts an Annual Meeting of the House of Delegates in the fall of each year. This is the primary forum for discussing the future course of the Association and an opportunity for physicians from across the state to gather. The annual meeting also includes a CME conference and opportunity for state medical specialty societies to coordinate meetings in conjunction with NDMA activities and speakers.

Doctor of the Day Program
The NDMA coordinates the Doctor of the Day program during each North Dakota legislative session. This program offers member physicians the opportunity to spend a day providing for the medical needs of the Senators and Representatives as well as observing and participating in the legislative process.

2013-14 Activity

The collection of reports in this, your Delegate Handbook, provides a good summary of the activity of your North Dakota Medical Association over the past twelve months, particularly the advocacy work on behalf of you and your patients. Our success in the 2013 ND Legislative Assembly was continued in the 2014 Interim ND Legislative Assembly due in large part to your continued commitment to a strong NDMA and strong participation by our NDMA members. Our efforts in the past twelve months have seen the same level of commitment by your physician leadership in adhering to the principles set by this House of Delegates last year.

As President, *the importance of involvement and leadership of physicians within NDMA and their communities* has been a key theme for Dr. Strinden this past year as he has traveled and talked with district societies, physicians, payors, agency heads, our Congressional Delegation, and legislators and other policymakers about the future of medical services in North Dakota and, in particular, national health system reform.

It has been my distinct pleasure to work with Dr. Strinden as President over the past year as he has truly been working hard in his commitment to you and your patients.

The Report of the Vice President as Chair of the Council reviews all the work of the Council and commissions, which is the Association's policymaking board charged with implementing the directions set by this House of Delegates. This past year, Dr. Geier led the Council through monitoring and advocating with the new Health Care Reform law and substantial Congressional activity; implemented the various resolutions and policies adopted by this House in 2013; developed an operational budget; and addressed specific policy issues as raised throughout the year.

The Report of the Secretary-Treasurer, Dr. Nammour, provides you with information about Association financial condition and membership trends. Non-dues revenue continues to constitute a substantial portion of the financial base for NDMA activities, as your NDMA staff works under administrative agreements to provide administrative and lobbying services for specialty and district societies, and other physician organizations. Each year an operating budget is developed based on a core office staff of four full-time employees who perform a variety of roles and responsibilities.

Several districts have been very active this past year and others have not. The NDMA staff is always available to discuss meeting ideas and activities with Districts and to assist in planning or administration. NDMA also provides ongoing administrative services to the Sixth District Medical Society, including meeting planning.

The reports of your NDMA members as physicians on boards, agencies and other organizations also contribute to the collective influence of physicians: Drs. Klein and Glasner on the BlueCross BlueShield of North Dakota Board of Directors, Dr. Eric Johnson on the Tobacco Prevention and Control Advisory Committee, Dr. Ranum on the ND Trauma Committee, Dr. Beattie on the MMIC Board of Directors., Dr. Hostetter, Dr. Booth and other physicians on the Medicaid Drug Utilization Review Board, several physicians on the ND State Board of Medical Examiners, and others. The participation by your colleagues in these important positions is absolutely critical for ensuring input by the medical community in the daily decision making that occurs in state agencies and other organizations. Your NDMA staff also participates in a variety of government and other meetings on behalf of ND physicians, including Legislative Council interim committees and meetings of various government agencies, which became a very substantial role for NDMA this past year, particularly the interim Health Care Reform Review Committee which addressed factors influencing health care insurance costs and the impacts of federal health system reform. NDMA staff also work continually with other health care organizations including individual clinics and hospitals, health care systems, the North Dakota Hospital Association, the Health Policy Consortium, and others on issues with which we share common interest.

NDMA Staff

We have a strong staff capacity in NDMA. While the NDMA staff is small – Leann Benson, Katie Fitzsimmons, Annette Weigel, and myself – we are able to continue to effectively leverage limited resources in a manner that allows for maximum participation by ND physicians in the forums that impact your practice.

In addition, your staff continues administrative work for several state specialty societies, which has not only provided a source of non-dues revenue for NDMA, but has allowed for better coordination and communication around important issues and even meeting planning. NDMA currently provides administrative support for the North Dakota Society of Eye Physicians and Surgeons, North Dakota Society of Anesthesiologists, North Dakota Orthopaedic Society, North Dakota Psychiatric Society, and the North Dakota Chapter of the American College of Surgeons. Other administrative arrangements are in place for the North Dakota Trauma Foundation, North Dakota Trauma Committee, and the Sixth District Medical Society. These efforts require substantial staff time and commitment.

Leann and Annette work hard to accomplish all the things that need to get done. Leann wears multiple hats in serving as the Chief Operating officer, financial and office manager, and as the person that ensures our compliance with federal and state election, tax and other requirements. Annette provides a range of administrative support and is likely the person you will talk to when you call the NDMA office. Katie is the communications officer, and works on the *ND Physician* and the e-physician every week. Regular contact with our members is important to all of us. We all provide varying levels of support for state specialty societies and NDMA's commissions, PAC, and Council.

We also work together with our medical society partners at all levels, including the American Medical Association, national specialty societies and our state specialty chapters. NDMA has a strong commitment to the AMA Advocacy Resource Center (ARC). The ARC was created in 1997 as a partnership between the AMA and state medical associations to enhance and advance the collective state legislative advocacy efforts of organized medicine.

Clear and Relevant Communication

Communication strategies are a key component of the NDMA strategic plan. Our communications strategy continues to include ongoing improvement of the NDMA website at www.ndmed.org and the use of e-mail at appropriate intervals to keep you informed of advocacy activities and other opportunities. Our *ND Physician* publication will continue to be published electronically as a way to showcase your activities and keep you updated in a different format.

Involvement, advocacy and communication. In conclusion, this is how we continue to improve our service to members. Give us your suggestions – are there other *better* ways to keep you informed and involved; are there better ways to ensure that NDMA is proactive in its advocacy for medicine and your patients, and are there better ways to communicate what we do or what we need?

Thank you for being involved in your Association, and enjoy the company of your colleagues in this 127th annual meeting!

Respectfully submitted,
Courtney Koebele, JD
Executive Director

Council Minutes
Thursday - Friday, October 3-4, 2013

Ramada Plaza Suites, Fargo

Call to Order – A meeting of the North Dakota Medical Association Council was held Thursday, October 3, 2013. Steven Strinden, MD, council chair, called the meeting to order at 12:00.

Council members present: Misty Anderson, DO; Robert Beattie, MD; Michael Booth, MD; Stephanie Dahl, MD; Deb Geier, MD; Kimberly Krohn, MD; Steven Mattson, MD; Shari Orser, MD; Sarah Schatz, MD; Steven Strinden, MD; and Harjinder Virdee, MD.

Council members absent: Joe Adducci, MD; Paul Bahal, MD; Catherine Houle, MD; Parag Kumar, MD; Timothy Luithle, MD; Fadel Nammour, MD; Rolf Paulson, MD; Keith Rau, MD; Mark Rodacker, MD; Shelly Seifert, MD; Thomas Strinden, MD; Randolph Szlabick, MD; Rory Trottier, MD; and Dennis Wolf, MD.

Staff present: Leann Benson, Katie Cashman, Courtney Koebele, JD; and Annette Weigel.

Guests present: Susan Bailey, MD, AMA Board of Trustees; Terri Folk, AMPAC; Jen Lee, AMA; and Lyle Thorstensen, MD, AMPAC.

Additions to the Agenda
No additional items were added.

Minutes from 8/27/13
8/27/13 meeting minutes were accepted as presented.

Steven Strinden, MD, welcomed the group and introduced the guests and led group introductions.

Dr. Susan Bailey provided remarks to the group and applauded everyone's participation.

Courtney M. Koebele, JD, Executive Director of NDMA, and Steven P. Strinden, MD, NDMA Vice President and Council Chair, presented the resolutions to the group, all of which were approved to go to the House of Delegates and Reference Committee.

Resolution No. 1: Gun Safety
Federal government passed a regulation that prohibits the CDC from studying gun safety. The council discussed bringing the resolution to the AMA House of Delegates to make a larger impact.

Resolution No. 2: PDMP
This will prove to be a hot topic in 2015 legislature and NDMA's interest in this now will carry weight with legislators. The Board of Pharmacy and NDHIN are working to resolve the access issues with the PDMP, as that alone can serve as a barrier to regular use by physicians. Also, with the federal system on a separate system (VA hospitals, IHS), checking the PDMP may provide a false sense of security. Along with the access issues, the council agreed that interconnectivity with other states is crucial.

Resolution No. 3: IPAB
Dr. Booth drafted this resolution as he feels "this is the single most damaging aspect of the ACA." Dr. Thorstensen added that AMPAC has strongly opposes this as well, and repeal bills have been proposed in the House and Senate. Senator Hoeven favors a repeal; Senator Heitkamp might require persuading.

Resolution No. 4: Disrespect and Derogatory Conduct in the Patient-Physician Relationship
It was recommended that the resolution be strengthen by broadening the language to include all physicians from being discriminated against. However, the group recognized that it can go on record to say what behavior is inappropriate, but it cannot legislate prejudices. Issues of credentialing, truth in advertising, and refusal of care were brought up and the group will look to Dr. Alberto, the drafter of the resolution, for more clarification when it is brought to the House of Delegates.

Resolution No 5: Physician-Led, Team Base Care
Here, issues of credentialing, truth in advertising, and the use of the term “patient centered medical home” were at the forefront. The AMA has conducted studies that show physician-led teams out-perform other non-physician-led teams. As other groups advocate for expanded responsibilities for all levels of nurses and other non-physician providers, NDMA needs to remain a strong advocate for physician-led teams.

Resolution No 6: Raise North Dakota’s Tobacco Tax
Raising tobacco taxes has been statistically proven to lower tobacco use, especially in teens. Though no one in the group advocates more taxation on a personal level, as an organization, supporting this tax will have good implications on the health of North Dakotans. Also, the group was in favor of promoting the tax revenue from this would be routed to tobacco cessation programs, but no motion was made to declare such intentions.

Resolution No. 7: Health Website Ratings
Dr. Bailey was going to check with AMA contacts to see if a similar resolution already exists or if one is in the works. As this is a larger issue than what affects the physicians of North Dakota, and knowing that NDMA cannot regulate the internet, the notion of amending this resolution to bring it to the AMA in June 2014 was favored.

AMPAC

Lyle Thorstenen, MD, spoke to the group about what AMPAC does: fighting for the SGR repeal, working to get individuals who are friendly to medicine into elected offices, and other issues. He introduced his colleague, Terri Folk, and they provided individuals with the opportunity to donate to AMPAC. He also showed off his schnazzy necktie, which serves as an incentive gift for donors.

With no reports from the NDMA President, A. Michael Booth, MD; the AMA Delegate, Robert Beattie, MD; the AMA Organized Medical Section Representative, Shari Orser, MD; or the NDMA Secretary, Debra Geier, MD; the Council Chair called on Courtney M. Koebele, JD, to provide her report to the Council.

NDMA Executive Director’s Report - Courtney M. Koebele, JD

February Retreat
This meeting, most likely to be held on Saturday, February 8, will convene to discuss the Personhood Resolution (HCR 4009) which will be on the ballot in November 2014. The tentative schedule for the day would be: start at Noon with a lunch meeting, invite speakers, adjourn, and then offer a dinner, for those that would be able to stay. Koebele contacted Steve Morrison, UND School of Law professor, as a possible speaker as he could educate the group about what a passage of this would mean for the state of North Dakota. Issue such as IVF, birth control, and end of life care were at the top of the list. Also, inviting a public relations expert to address how to handle this issue appropriately would be in the best interest of the organization. Koebele mentioned Odney and MABU, two firms in Bismarck that could serve as possible representation for NDMA, as NDMA does not want to become the face and name at the center of the campaign. NDMA needs to emerge from the November 2014 elections in-tact.

Supreme Court Case - Medical Abortion Law From 2011
This was overturned and is on appeal. NDMA has been approached to file an Amicus Curiae brief and Koebele researched the pros and cons of filing, at the request of the council. It is safe to anticipate press coverage if NDMA filed a brief. NDMA did not appear at the state court level, so the State Supreme Court cannot review new evidence. It can review a new brief, but cannot use that while weighing their decision. In Koebele’s opinion, after

researching the options and investigating the costs ($5-10,000 estimate), the benefits of filing a brief do not outweigh the disadvantages for NDMA at this point.

The group discussed the issue at length, especially concerns with prescribing becoming federally regulated.

Robert Beattie, MD, moved for NDMA to not proceed, as NDMA would not be able to control the message, public perception, and member perception.
The motion died for lack of a second

Stephanie Dahl, MD, moved to support the filing of an Amicus brief. Kimberly Krohn, MD, seconded the motion. Discussion continued and Sue Bailey, MD, asked if AMA legal counsel offered any insight or assistance.

The motion on the floor was called to a vote, and the motion passed. Next steps: Koebele will work with Dr. Dahl and legal counsel to move forward.

CDL CME Certification Issue
NDMA is partnering with Montana, which has done all the work to offer this training. It will be online, at no cost to NDMA, but it will cost members $435 to take the course. Koebele will advocate for more testing sites to make this more accessible, but ultimately, that decision rests with the testing/certifying entity.

Conflict Of Interest Policy
This is not a concern for this group nor is it a legal requirement, but as most other state medical societies have a written acknowledgement of such a policy, it might be in NDMA's best interest to follow suit. With this issue being new news to council members, this was tabled for the time being.

DocbookMD
NDMA has researched and discussed DocbookMD for almost a year. NDMA is now up and running with the smartphone app that allows physicians and their care teams to send HIPAA-compliant messages. The app is very helpful and easy to use, but most exciting is that this serves as a true exclusive-member benefit. Some medical societies have seen individuals join a medical association just to gain access to this app and NDMA hopes for the same fate.

Other Business

Koebele reviewed the schedule for the rest of the Annual Meeting.

Stephanie Dahl, MD, volunteered to be on the Reference Committee.

Tentative date for the next meeting: Tuesday, December 10, 2013

Adjournment: There being no further business on the agenda, the meeting was recessed at 2:40 p.m.

Friday, October 4, 2013

The meeting was reconvened on Friday, October 4, 2013, at 1:30 p.m.

It was moved and seconded that Stephanie Dahl, MD be elected the Vice-Chair of the Council. Motion carried.

The next council meeting will be on December 10, 2013.

The meeting adjourned at 1:32 p.m.

Council Minutes
Tuesday, December 10, 2013

Conference Call

Call to Order – A meeting of the North Dakota Medical Association Council was held Tuesday, December 10, 2013. Debra Geier, MD, council chair, called the meeting to order at 5:30 PM.

Council members present: Joe Adducci, MD; Misty Anderson, DO; Robert Beattie, MD; Michael Booth, MD; Deb Geier, MD; Kimberly Krohn, MD; Parag Kumar, MD; Steven Mattson, MD; Fadel Nammour, MD; Shari Orser, MD; Sarah Schatz, MD; Steven Strinden, MD; and Harjinder Virdee, MD.

Council members absent: Paul Bahal, MD; Stephanie Dahl, MD; Catherine Houle, MD; Timothy Luithle, MD; Rolf Paulson, MD; Mark Rodacker, MD; Shelly Seifert, MD; Thomas Strinden, MD; Randolph Szlabick, MD; Rory Trottier, MD; and Dennis Wolf, MD.

Staff present: Leann Benson, Katie Cashman, and Courtney Koebele, JD.

Additions to the Agenda
No additional items were added.

Minutes from 10/3/13 and 10/4/13
10/3/13 and 10/4/13 meeting minutes were accepted as presented.

Report of the President, Steven Strinden, MD

Announcement: Kimberly Krohn, MD, was appointed as the Chair of the Commission on Education.

Sanford Health: 137 physicians have opted in, approximately 300 to go. The general feedback is that people are willing and wanting to opt-in, but most of them do not read emails. The plan now is to divide up the 300 remaining names into groups of 15-20 physicians for individuals on the council to contact.

NDMA Council Retreat: February 8, 2014 in Bismarck, 12:00 – 6:00 PM, at the NDMA office. Steve Morrison of the UND School of Law is slated to present the constitutional implications of the Personhood issue. Mike Mabin of the MABU agency (a PR firm) will present and facilitate a strategy session about how NDMA can protect its name and make its intentions clear.

2014 Annual Meeting Schedule: A one-day meeting schedule was proposed and briefly outlined. Dr. Strinden suggested that if the award winners were unable to attend the luncheon event, the home district society of a recipient could host a recognition meal instead. Additionally, Dr. Strinden mentioned that the state of Minnesota is getting rid of its House of Delegates, upping the meeting schedule of the council, all while facilitating good, intentional round-table discussions at their Annual Meeting. These could be interesting developments to watch. It was brought up that in the future, it'd be helpful to poll the membership on what they'd like to see in an Annual Meeting.

Dr. Strinden moved to support the format change for the Annual Meeting, Dr. Nammour seconded the motion. The motion was approved.

AMA Interim Meeting: While attending the meeting in November, the NDMA delegation had the opportunity to meet with Senator Heitkamp and her staff, Senator Hoeven's staff, and Representative Cramer and his staff, to discuss the SGR and what it means to North Dakotan physicians.

AMA Delegate's Report – Robert Beattie, MD

Dr. Beattie called attention to the summary in the agenda and highlighted the extensive discussion about the SGR Repeal.

AMA Organized Medical Staff Section Representative – Shari Orser, MD

Dr. Orser referred to the summary in the agenda and highlighted: the Medical Staff and Hospital Engagement of Community Physicians; the Two-Midnight Rule; CMO Qualifications; ICD-10 training; and Certification and Licensure.

NDMA Executive Director's Report - Courtney M. Koebele, JD

Licensure Issue: This was brought to NDMA by Dan Kelly, the Chief Executive Officer of McKenzie County HealthCare Systems, and regards ND Century Code 50-02-11-03.1 (requires physicians pass their board exams in three attempts or less; if it takes more attempts, they have to meet a list of other criteria). Mr. Kelly asked NDMA to support his efforts during the 2015 Legislature session to change this portion of the Century Code. He has addressed his concerns with BOMEX, but wanted a feel from the NDMA Council. The council discussed regulations in other states, especially neighboring states, whether or not this was an issue that requires action on the legislative level or if this is an administrative concern, and data that should be collected before taking a stance. This issue was tabled for the January meeting, pending data collection by Koebele.

PDMP: Katie Cashman reported about the latest happenings and discussions that have come out of the Reducing Pharmaceutical Narcotics Taskforce, namely, the discussions around mandatory reporting and mandatory PDMP sign up. Cashman asked for feedback on the parentslead.org website and the education that medical students receive on opioid prescribing.

State Legislative Strategy Conference: Dr. Adducci moved that the council financially support NDMA attendance, Dr. Strinden seconded the motion, and it passed.
Amicus Brief Update: Overall, Koebele was pleased with how the brief turned out, it came in under budget, and the North Dakota Supreme Court will hear arguments tomorrow (Wednesday, December 11).

ND Society of Radiologic Technologists: Courtney suggested that this issue be referred to the Council on Legislation.

Secretary/Treasurer's Report – Fadel Nammour, MD

NDMA Membership Report: Dr. Nammour suggested that it might be easier to dole out the unsigned-up members by specialty.

Current Financial Report: Dr. Nammour asked for clarification on the budget report, as it states that NDMA's net income is at 214% of budget. Leann explained that December's bills are yet to be paid and she estimates that NDMA will come in right at or below budget at the end of the year. The budget conversation will continue in January.

Other Business

The next council meeting is slated for Tuesday, January, 14 at 5:30 PM.

Adjournment: There being no further business on the agenda, the meeting was adjourned at 6:40 PM.

Council Minutes
Tuesday, January 14, 2014

Conference Call

Call to Order – A meeting of the North Dakota Medical Association Council was held Tuesday, January 14, 2014. Debra Geier, MD, council chair, called the meeting to order at 5:33 PM.

Council members present: Joe Adducci, MD; Misty Anderson, DO; Robert Beattie, MD; Michael Booth, MD; Deb Geier, MD; Kimberly Krohn, MD; Fadel Nammour, MD; and Steven Strinden, MD.

Council members absent: Paul Bahal, MD; Stephanie Dahl, MD; Catherine Houle, MD; Parag Kumar, MD; Timothy Luithle, MD; Steven Mattson, MD; Shari Orser, MD; Rolf Paulson, MD; Keith Rau, MD; Mark Rodacker, MD; Sarah Schatz, MD; Shelly Seifert, MD; Thomas Strinden, MD; Randolph Szlabick, MD; Rory Trottier, MD; Harjinder Virdee, MD; and Dennis Wolf, MD.

Staff present: Leann Benson, Katie Cashman, and Courtney Koebele, JD.

Additions to the Agenda
No additional items were added.

Minutes from 12/10/13
12/10/13 meeting minutes were accepted as presented.

Report of the President, Steven Strinden, MD
Dr. Strinden did not have anything to report at this time.

NDMA Executive Director's Report - Courtney M. Koebele, JD
Nursing Home Federal Regulations: Koebele informed the Council that the North Dakota VA Long Term Care facility has raised the issue of whether a Nurse Practitioner could be the Medical Director of a long term care facility. The Council discussed the fact that we are supportive of all mid-levels to practice within the full scope of their practice, but that this would represent an expansion of that scope. Shelly Peterson, the President of the North Dakota Long Term Care Association, is a friend of ours in this issue, but some of her members have contacted Senator Judy Lee to investigate legislative action to change the parameters of eligibility for Medical Directors to include NPs or other mid-levels. It appears to be a federal regulation, which cannot be changed by the state. The Council agreed to refer this issue to the Commission on Legislation, which will meet in February 2014.

Licensure Exam/Number of Testing Times Allowed: This is a follow-up from the discussion held during the December council meeting. In the past, the Board of Medical Examiners considered allowing four test attempts, but voted it down. In the example we considered during December's meeting, Dan Kelly in Watford City had a physician hired, but since she needed four attempts to pass, her North Dakota licensure was not secured. However, after careful review, BOMEX found a way to legitimately certify her North Dakota license. Koebele explained that it is an administrative rule that can be changed by the BOMEX and does not require legislative action. The council referred this issue to the Commission on Legislation, to keep this on the radar.

Secretary/Treasurer's Report – Fadel Nammour, MD
Consideration and Action On the 2014 Budget, Including 2013 Year-End Budget/2014 Proposed Budget, Staff Salary Adjustments, and the Executive Director Salary: Courtney Koebele, JD, and Leann Benson presented the proposed 2014 budget which projects total revenue from all revenue sources to be $588,200 which is $20,668 less than the 2013 estimated actual revenue. Total expenses for 2014 are anticipated to be $565,908, which is $38,955

less than the 2013 approved budget. As proposed, the 2014 operating budget has a positive bottom line of $22,292. The proposed budget does not include 2014 salary adjustments for staff.

Koebele presented recommendations to the council for salary increases and reviewed background information including job service information and comparable salaries in surrounding states for similar positions.

It was moved, seconded, and carried to accept the proposed 2014 operating budget and to include an increase in salary of 5% for staff.

The Council went into executive session for evaluation of the Executive Director. The Council approved an increase in salary of 5% for the executive director.

Other Business

The next council meeting will be the NDMA Board Retreat on Saturday, March 1, 2014, from Noon-5:00 PM at the NDMA office in Bismarck.

Adjournment: There being no further business on the agenda, the meeting was adjourned at 6:16 PM.

Council Minutes
Saturday, March 1, 2014

North Dakota Medical Association Office, Bismarck

Council members present: Misty Anderson, DO (by phone); Paul Bahal, MD; Robert Beattie, MD; Michael Booth, MD; Stephanie Dahl, MD (by phone); Deb Geier, MD; Kimberly Krohn, MD; Parag Kumar, MD; Fadel Nammour, MD; Shari Orser, MD; and Steven Strinden, MD.

Council members absent: Joseph Adducci, MD; Neville Alberto, MD; Catherine Houle, MD; Paul Knudson, MD; Timothy Luithle, MD; Steven Mattson, MD; Rolf Paulson, MD; Keith Rau, MD; Mark Rodacker, MD; Sarah Schatz, MD; Shelly Seifert, MD; Thomas Strinden, MD; Randolph Szlabick, MD; Rory Trottier, MD; Harjinder Virdee, MD; and Dennis Wolf, MD.

Staff present: Leann Benson, Katie Cashman, Courtney Koebele and Annette Weigel.

A meeting of the North Dakota Medical Association Council was held on Saturday, March 1, 2014 to discuss the Personhood Resolution (HCR 4009) which will be on the ballot in November 2014. Steve Morrison of the UND School of Law presented on the constitutional implications of the personhood issue. Mike Mabin of the MABU agency (a PR firm) presented and facilitated a strategy session about how NDMA can protect its name and make its intentions clear.

Council Minutes
Tuesday, May 27, 2014

Conference Call

Call to Order – A meeting of the North Dakota Medical Association Council was held Tuesday, May 27, 2014. Debra Geier, MD, council chair, called the meeting to order at 5:30 PM.

Council members present: Joe Adducci, MD; Misty Anderson, DO; Michael Booth, MD; Deb Geier, MD; Kimberly Krohn, MD; Shari Orser, MD; and Steven Strinden, MD.

Council members absent: Neville Alberto, MD; Paul Bahal, MD; Robert Beattie, MD; Stephanie Dahl, MD; Catherine Houle, MD; Parag Kumar, MD; Timothy Luithle, MD; Steven Mattson, MD; Fadel Nammour, MD; Rolf Paulson, MD; Mark Rodacker, MD; Sarah Schatz, MD; Shelly Seifert, MD; Thomas Strinden, MD; Randolph Szlabick, MD; Rory Trottier, MD; Harjinder Virdee, MD; and Dennis Wolf, MD.

Staff present: Leann Benson, Katie Cashman, and Courtney Koebele, JD.

Additions to the Agenda
No additional items were added.

Minutes from 1/14/2014
Motion: The January 14, 2014 meeting minutes were approved as presented by Joe Adducci, MD; seconded by Michael Booth, MD. Motion approved.

Report of the President, Steven Strinden, MD

NDMA Annual Meeting

- Dr. Strinden reminded to the districts to elect delegates for the NDMA Annual Meeting
- Resolutions: if anyone has ideas or suggestions for resolutions, please contact NDMA office
- The two awards: if anyone has any nominations to submit, please complete the form and send to the NDMA office
- Elect officers/nominations need to be brought forth
- Gift basket to be auctioned off for the foundation scholar's fund
- Changed format: HOD all on Friday, council will meet on Thursday with a dinner on Thursday night

Dr. Strinden relayed how much fun he has had at district meetings across the state, especially in Valley City.

Report of the Vice President, Deb Geier, MD

Review of the Executive Director Annual Evaluation Form/Process
We are behind on this, as this would typically be conducted in December. The evaluation form was discussed. Dr. Booth thought that it was a pretty good form and Dr. Orser agreed. Once this has been completed by all members of the council it will then be reviewed with the ED with the President. Dr. Krohn suggested that it be sent electronically and Leann confirmed that it would be sent over SurveyMonkey.

NDMA Executive Director's Report - Courtney M. Koebele, JD

NDMA Website (Document 11)
We requested an estimate from MABU (a local Bismarck firm) for a new website and add-ons. Our current website is operated under MABU. Two years ago, we invested approximately $8000 with KK Bold for a similar website upgrade. This was done under a previous employee; she has since left. The KK Bold site is still not finished as KK Bold has not been easy to work with and has been very expensive. We have enjoyed working with

MABU and we would like to bring our website up to speed with them, as we estimate it to be less expensive in the long run. We are looking at getting an overall facelift, integrate a bill tracker, webforms to pay dues and to register for the annual meeting (these were not available options through the KK Bold site), a newsletter upgrade, and several other refinements. Though our estimate rings in around $7660, we estimate the final estimate will be around $10,000. Dr. Strinden brought up the budgeting of this project, as it is not outlined there currently nor is there an allotment. Dr. Geier tabled this discussion until the current financial reports portion of the meeting.

Constitutional Amendment, Measure 1 (Document 5)
Our discussion at the March retreat focused on that after June 10, we would focus on an information campaign to our members. Courtney shared materials from Mississippi, a very conservative state, when it faced this issue in 2011. Mississippi's medical association's president sent an email to the membership email from the president to the members, explaining the exact reasons why they were against it. The measure was voted down. Dr. Strinden has started compiling a list of unintended consequences into a document. Dr. Strinden mentioned that we might have to answer a lot of questions, and this list of unintended consequences could help with that.
Dr. Luke in Valley City requested a handout for her patients to educate them about the issue and our stance. This, however, might step over the line of what we want to do. Medical students in Minot also came forward asking for more information/materials about this issue.

Dr. Strinden brought up that little things can turn into large issues. Dr. Orser mentioned that we can leave this information on our website and make it accessible to people; we cannot control what we do with the materials once we post them, thus, what we put out there needs to be carefully crafted and we plan to work on this in late June.

Telemedicine Reimbursement (Document 6)
This informational talking point center around a letter from Avera, out of South Dakota, to George Keiser, the chairman of the Health Care Reform Committee. Avera offers a telemedicine ER service. The hospitals pay a fee and doctors can contact this service if they have questions or concerns. Avera complains that they are not reimbursed for some telemedicine items: home health, remote patient monitoring, and store and forward services, so Avera is asking the state legislature for a telemedicine payment parity. BCBSND pays for telemedicine, but not for the above listed items.

Avera utilized some bill language that was recently used in Montana and this will be discussed in mid-June. And they are looking to us whether we'll be for or against this movement. No one is against telemedicine (NDHA, NDMA, etc.) but BCBSND is concerned about the mandate for coverage. State law says that if the legislature passes anything in this regard, it needs to go through the PERS system, and Courtney suspects that the bill will be amended to accommodate that track. We should stay neutral but supportive of telemedicine, until they figure out payment. Courtney will monitor this issue and provide timely updates.

Involuntary Commitment Proceedings (Document 7)
Dr. Robert Olson testified in front of the Health Care Reform committee to request an amendment to the law that does not allow Advanced Practice Registered Nurses testify during commitment hearings. Currently, only psychiatrists, psychologists, and LACs can testify, which can create a burden, especially given that these advanced practice nurses would be just as capable to provide credible testimony.
Courtney had some concerns with the wording in sections 2A and 2B, as she needs to ensure the language is within the scope of practice of advanced practice nurses. Dr. Booth suggested that PAs get included in the language while this is up for amending.

PDMP Prescriber Guidelines (Document 8)
This informal committee meets frequently and we have been a strong presence, along with many other shareholders. This taskforce came from several legislators who want to see mandatory checking of the PDMP become law. After nearly a year of meeting, the group resolved to let each administrative board develop rules in

order to avoid legislation. NDMA has been approached by Duane of BOMEX to develop some reasonable administrative rules.

We are looking for feedback to define some situations that would allow physician to prescribe a narcotic without having to check the PDMP, such as cases of hospice care, people in nursing homes, etc.

Another issue that will arise in this will be when would physicians be required to sign up for the PDMP? And what will that process look like? The Board of Pharmacy seems to be behind, but they are working on getting integrated with the NDHIN and other EHRs. Things are going as well as could be expected, if not better.

Dr. Krohn mentioned that things need to be thought through so we don't create more barriers for patients to receive necessary care and that we allow physicians to care for patients and not take on law enforcement duties. Dr. Booth suggested that the BOMEX needs to establish disciplinary action procedures. The board needs some guidance what should be a red flag and what should not be. The PDMP is just one tool to address this problem. Dr. Geier suggested an added exception under "c": institutionalized people (nursing homes, etc.)

Dental Case Management Outreach Services (Document 9)
NDDA approached NDMA to see if we support their position.
There has been a movement to create a mid-level dentist in the name of access, which the dentists oppose. NDDA wants to create, instead, a dental professional medical home system that would identify high-risk patients, link them to a dental home, and therefore build more access.

NDMA's understanding is that there are plenty of dentists in North Dakota, it is more of a distribution issue. Creating this mid-level position would not solve the access issue.

Motion: Dr. Orser moved to support NDDA; Dr. Misty Anderson seconded it. Motion approved.

Raise it For Health Coalition (Document 10)
NDMA is a member of this coalition, pursuant to the 2013 HOD's resolution. Though this tax increase would target a poor population and tax increases are not popular, the research that proves a higher tobacco tax curbs smoking in youth is irrefutable and is further in line with our mission.

Report of the Secretary-Treasurer, Fadel Nammour, MD

Membership Report (Document 12)
In the absence of the secretary-treasurer, Dr. Geier requested that the Executive Director summarize the report. Ms. Koebele reviewed the NDMA Membership Report which shows 2014 dues received as of May 23, 2014 of 877 regular active members toward the 2014 goal of 937. In the materials, NDMA listed what forms of recruitment/retention have been decimated. Additionally, seven new members enrolled today (from Sanford). Also included was a listing of 212 physicians that were just dropped from the membership roster for failure to pay 2014 dues. Effective recruitment truly requires person-to-person contact. Courtney would like to send out lists of 10-20 physicians for each person to recruit/talk to.

Current Financial Report (Document 13)
Courtney reviewed the current balance sheet for which there were no unusual items to report. The profit and loss statement versus actual as of May 22, 2014 was reviewed. It is estimated that membership dues income for 2014 will be $15,000 less than budgeted and administrative services, grant, and education program income will be $23,300 more than budgeted. Staff continues its ongoing commitment to improve membership, enhance current non-dues sources of revenue, and reduce expenses where possible. That said, it is estimated that the 2014 bottom line will be $13,507 or $8,957 more than the approved budget.

NDMA Financial Support for Medical Students
In 2002, we started to pay for each UND SMHS medical student's AMA membership fee. In turn, the UND SMHS AMA Section receives a commission from these memberships. The commission received is to be used to financially assist in sending medicals students to the AMA Annual and Interim Meetings. Last year, we paid $4,500. We are unsure of the impact this truly has on the medical students and if the funds are being used to send students to the meetings. To NDMA's knowledge, students haven't participated in the annual meeting for the last few years.

Dr. Geier suggested that Courtney contact the school and find out what is happening with the AMA commission. Also, it could be a question of the students having the scheduling opportunity to attend the meeting, which could be a question for Dean Wynne.

Motion: Dr. Krohn made a motion to continue paying for the medical students' AMA dues for this year. Dr. Orser seconded the motion. The motion was approved but the issue will be reviewed next year.

AMA Partnership for Growth Agreement
Each year (signed July 1, 2013), NDMA has an agreement with the AMA for billing. It requires a significant amount of work and allows the AMA dues to be listed on our bills. We receive a commission on the AMA dues collected, but listing the AMA dues on our bill can be a deterrent for members to join NDMA. Only 17 states were enrolled in the 2014 AMA Partnership for Growth.

Motion: Dr. Strinden moved to remove the AMA listing from the NDMA bills; Dr. Krohn seconded the motion; motion approved unanimously.

Dr. Geier brought the website issue forward and recapped Leann's estimation that NDMA will be in the black by $13,500 and the estimated cost for the website is around $10,000.

Motion: Dr. Strinden moved that NDMA pursue the website project with MABU. Dr. Booth seconded the motion; motion approved unanimously.

Other Business
The next council meeting will be in July and Courtney will be in touch for scheduling.

Adjournment: There being no further business on the agenda, the meeting was adjourned at 6:50 PM.

Officers of the NDMA District Medical Societies

First District
President: Neville M Alberto MD
Vice-President: Jaise T Poulose MD
Secretary-Treasurer:
Past President: Susan M Mathison MD

Second District
Vacant

Third District
President: Randolph E Szlabick MD

Fourth District
President: Kimberly T Krohn MD
Secretary-Treasurer: Steven R Mattson MD

Fifth District
President: Genevieve M Goven MD
Secretary-Treasurer: James B Buhr MD

Sixth District
President: Rhonda R Schafer McLean MD

Seventh District
President: Dale J Ernster MD
Secretary-Treasurer: Larry E Johnson MD

Eighth District
President: Joseph E Adducci MD
Secretary-Treasurer: John B Andelin MD

Ninth District
President: Kamille S Sherman MD
Secretary-Treasurer: Dennis E Wolf MD

Tenth District
President: James G Mehus MD
Secretary-Treasurer: Charles J Breen MD

Eleventh District
President: John P Joyce MD
Vice-President: Jennifer Sheffield MD
Secretary-Treasurer: Thomas E Jacobsen MD

Report of the First District Medical Society

The First District met eight times with speakers at several meetings
Sept - Courtney Koebele : NDMA overview
Oct - Luther Stueland : Affordable Care Act
Nov – Dr. Steven Strinden - NDMA resolutions, update of the annual meeting
Dec - Christmas Social
Jan – Dr. Joshua Wynne - North Dakota work force initiative
Feb - Valentine night out
Mar - Dr Jaise Paulose - International medical graduates in North Dakota
April - DMF - Lend a hand program

The first district also co-sponsored TedEx Fargo this year and Health Pitch in addition to the UND Medical Student Teddy Bear project.

Respectfully submitted,
Harjinder Virdee, MD
First District Councillor

Report of the Fourth District Medical Society

Our district officers include Kim Krohn as President and Steve Mattson as Secretary/Treasurer

Our society met twice this last year. We continue to have a difficult time attracting our physicians to the meetings, but the Minot Family Medicine Residency Program remains well represented at our meetings.

Our spring meeting included a talk by the new Chairman of the Department of Neurology, Jau-Shin Lou MD. He talked about peripheral neuropathy. It was fun to meet the new Professor and he had just recently traveled around the state of North Dakota and was impressed and surprised at the vast flat prairie lands throughout the state. He was looking forward to exploring other areas of the state. It is always interesting to hear from new implants to the state, and see our state from their unique perspective.

The fall meeting hosted Dr. Juliana Reeves from Williston, who talked about Common Disorders of the Eye. Her lecture was well received and filled with clinically relevant data.

We will be sending three delegates to the state convention, Kim Krohn, Steve Mattson and Paul Bahal.

Respectfully submitted,
Steven R. Mattson, MD
Fourth District Councillor

Report of the Fifth District Medical Society

Fifth District held a meeting on April 23rd at the Sabir's Dining and Lounge in Valley City. Dr. Joshua Wynne, Dean of UND School of Medicine and Health Sciences and Vice President for Health Affairs presented to our district about the progress of the new medical school building project and the Implementation of the Health Care Workforce Initiative.

Also presenting were Steve Strinden, NDMA President and Courtney Koebele, NDMA Executive Director who presented on the latest state and federal issues.

Report of the Sixth District Medical Society

The Sixth District Medical Society encompasses the central North Dakota counties of Burleigh, Morton, Grant, Emmons, Kidder, Logan, McIntosh, Oliver, Sheridan, McLean, Mercer, and Sioux.

The Sixth District met on April 22, 2014 at the Bistro restaurant. We heard a presentation on Implementation of the Health Care Workforce Initiative and an update on the UND School of Medicine and Health Sciences (UND SMHS) new building presented by Joshua Wynne, MD; University of North Dakota's Vice President for Health Affairs and Dean of the UND SMHS.

The Society's officers are: Rhonda Schafer McLean, MD, President, and Shelly A. Seifert, MD, Sixth District Councillor. Dr. Schafer-McLean's term will expire in 2014. The seat of Secretary-Treasurer is currently vacant due to RJ Moen, MD relocating to Indiana in September, 2014. Dr. Mark Rodacker who served as a member of the North Dakota Medical Association Council representing the Sixth District for the past several years has moved to Grand Forks. In August Dr. Laura Gehrig was nominated to fill his seat; however, she has recently resigned from Sanford and will be moving out of state. Administrative services for our District are provided by NDMA staff.

Other activities of the District this past year include:

- Financial sponsorship of a public service announcement about safe driving during back to school time
- Awards presented to medical student graduates: Erin Maetzold and Brittany Snustad
- Financially supported family medicine residents by payment of their NDMA dues
- Provided a financial donation in conjunction with First and Third District Medical Societies, to the UND Medical Students' Teddy Bear (TedMed) project. This project, formed by first-year students is a non-profit corporation to help the community. TedMed is a teddy bear clinic for kindergartners who bring in their teddy bear and partner with medical students in a one-on-one fun and engaging setting to perform a check-up on their teddies. The goal is to promote good health in children via their teddy.

Respectfully submitted,
Shelly A. Seifert, MD
Sixth District Councillor

Report of the Eighth District Medical Society

Our district officer is Joe Adducci, MD, who serves as president.

Our society did not have any notable events to report this year.

David Skurdal, MD, is the 8th District Delegate and Sara Solberg, MD, is the Alternate Delegate.

On July 8th we had a presentation from NDMA President Steven Strinden and Executive Director Courtney Koebele on state and federal issues.

Respectfully submitted,
Joseph E. Adducci, MD
Eighth District Councillor

Report of the Ninth District Medical Society

District 9 met twice this past year. The first meeting was held on March 25, 2014 where we heard a presentation by Joshua Wynne, MD, University of North Dakota's Vice President of Health Affairs and Dean of UND SMHS regarding the Implementation of the Health Care Workforce Initiative and an update on the new UND SMHS building. Also presenting to our group was Steve Strinden, MD, President of NDMA along with Courtney Koebele, NDMA Executive Director who updated us on state and federal issues. Our guests were greeted by Kamille Sherman, MD who arranged for a tour of the new St. Joseph's Hospital construction project.

A second meeting was held on September 24th. There were five of us in attendance (two potentially new members). Discussion took place regarding the UND School of Medicine and efforts to get more doctors involved at the district level.

Ninth District will be sending two delegates to the NDMA Annual Meeting in Grand Forks on October 3rd. Dr. Amy Oska will represent District 9 as our delegate and Dr. Kamille Sherman will represent us as the alternate delegate at the NDMA 2014 Annual Meeting in Grand Forks.

Respectfully submitted,
Dennis E. Wolf, MD
Ninth District Councillor

Report of the Commission on Ethics

Commission Members: Kristina A. Schlecht, MD, Chair; Jayaram S. Bharadwaj, MD; Charles E. Christianson, MD; Kurt W. Kooyer, MD; Robert D. McCartney, MD; Andrew J. McLean, MD; Kevin Mork, MD; Rolf R. Paulson, MD; Mary Ann Sens, MD; David W.C. Tsen, MD. **NDMA Officers**: Steven P. Strinden, MD; Debra M. Geier, MD; Fadel E. Nammour, MD; Misty K. Anderson, DO; A. Michael Booth, MD; Robert W. Beattie, MD; and Shari L. Orser, MD; (*Officers are ex-officio members of all NDMA Commissions)*; **Medical Students:** Marcus Geffre, Clifford Hall, III, and David Larson

The Commission on Ethics was created in 1998 to be a liaison with the North Dakota State Board of Medical Examiners and to provide guidance to members concerning ethical issues. Efforts this past year focused on participating in the Advanced Care Planning Coalition and the use of POLST (Physician-Ordered Life-Sustaining Treatment). POLST is a two-sided form designed to help health care professionals honor the end-of-life treatment desires of their patients. The form has physician orders that follow patient wishes and treatment intentions, and is designed to enhance the appropriateness and quality of patient care beyond the use of current advance directives.

The commission met once since the 2013 Annual Meeting and heard an update on the Advance Care Planning Coalition. NDMA partnered with the North Dakota Long Term Care Association and the NDQIO to form a task force to plan an Advance Care Planning Statewide Initiative. This initiative builds on the Advanced Health Care planning grant that NDMA received in 1999, and project called *The Matters of Life and Death*.

The coalition met on a monthly basis during this past year. The purpose of the initiative is to conduct an advance care planning environmental scan to gain a better understanding of the medical, cultural, philosophical, and political factors influencing end of life care in North Dakota. The initiative has gained impressive support from all health care entities in the state. Groups represented include the Long Term Care Association, the Hospital Association, Hospice of the Red River Valley, the State Health Department, Trinity Medical Center, St. Alexius Medical Center, Sanford and Altru.

After a year of planning, the ND Advance Care Planning Initiative is now officially Honoring Choices North Dakota. North Dakota Health Care Review, Inc., purchased the license to use the name and logo on behalf of NDACP for this year. NDMA was instrumental in securing a legal firm to provide pro bono assistance to Honoring Choices ND to incorporate as a nonprofit organization.

The commission also addressed the resolution referred to the commission from the 2013 HOD, regarding disrespect and derogatory conduct in the patient-physician relationship. The amended resolution encourages health organizations to develop practices to attend to patients who engage in abusive behavior towards physicians. The amended resolution will be submitted to the 2014 HOD.

Respectfully submitted,
Kristina A. Schlecht, MD, Chair

Report of the Commission on Legislation and Governmental Relations

Commission Members: Sarah L Schatz, MD; Chair; Warren E Albrecht, DO; MD; Robert W Beattie, MD; Ricky C Becker, MD; Steffen P Christensen, MD; Stephanie K Dahl, MD; Luis A Garcia, MD; Raymond S Gruby, MD; Emmet Kenney, Jr, MD; Ralph L Kilzer, MD; Robyn Knutson Bueling, MD; Douglas W Litchfield, MD; Thomas R Magill, MD; Timothy J Mahoney, MD; Fadel Nammour, MD; Vishnupriyadevi Parvathareddy, MD;Mary Ann Sens, MD; Thomas I Strinden, MD. **NDMA Officers**: Steven P. Strinden, MD; Debra M. Geier, MD; Misty K. Anderson, DO; A. Michael Booth, MD; and Shari L. Orser, MD; (*Officers are ex-officio members of all NDMA Commissions)*. **NDMGMA**: Kayla Friedt. **Medical Students**: Brendan Boe, Tatia Hardy, Bryan LaBore

The Commission on Legislation and Governmental Relations is charged in NDMA's bylaws to "address all appropriate legislation and actions of governmental agencies." The Commission met on two occasions since the 2013 Annual Meeting to consider legislative and governmental issues, and recommend NDMA policy on legislative issues to be considered during the 2015 North Dakota Legislative Assembly.

NDMA Preliminary Legislative Agenda

Broad Policy Concepts
As in past legislative sessions, NDMA supports the following broad policy concepts as part of its 2015 preliminary legislative agenda:

- Support efforts to enhance North Dakota's workforce climate for physicians and other health professionals
- Support additional state medical liability reforms – protect existing reforms
- Support the independent medical judgment of physicians in medical practice
- Support Medicaid payment increases for physicians and hospitals
- Support Medicaid program and management reforms
- Support public health initiatives
- Support ways to enhance patient decision making
- Support funding increases in the UNDSMHS budget
- Support efforts to encourage strategies and plans for health information technology
- Support expanded coverage for uninsured and underinsured people, including children
- Support physician scope of practice and oppose inappropriate challenges to that scope of practice

Medicaid Reimbursement: NDMA partnered with the North Dakota Hospital Association and the North Dakota Long Term Care Association to request a 4% increase for providers. The Governor's 2015-2017 budget will be released in October 2014. NDMA will pursue the increase in the 2015 legislative assembly.

Medical School: In 2011's and 2013's 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. The legislature granted 16 new residency slots, 16 more medical students, and 30 additional health science students.

- The RuralMed program, will be seeking increased funding because of the continued and increased interest from North Dakotan medical students.
- The 2013 Legislative assembly approved a new medical school building which is currently under construction. The 122.45 million was granted in two parts – the first in a $60,450,000 from general funds and the second phase of the project authorized the State Board of Higher Education to obtain a loan of $62 million from the Bank of North Dakota. The State Board of Higher Education is to seek funding from the 64th Legislative Assembly to repay any loan obtained for the second phase of the project.

PDMP Regulation: Policy makers have been studying the issue of how best to utilize the Prescription Drug Monitoring Program (PDMP). NDMA participated in a taskforce which concluded that the best approach would be for the licensing boards of the providers to develop rules for their licensees. NDMA is working with the North Dakota Board of Medical Examiners to develop proposed rules guiding the appropriate use of the PDMP.

Behavioral Health Initiatives: The interim Human Services Committee commissioned a study of North Dakota's behavioral health system and released a report in June 2014. Proposed legislation so far includes increased funding for substance abuse services and telemedicine services; and proposed changes in definitions and uniform licensing of providers.

Commitment Proceedings: The North Dakota Health Care reform committee approved a bill to expand which types of health care providers are allowed to testify at commitment hearings.

Telemedicine Payment Law: The North Dakota Health Care Reform Committee approved a bill that provides for telemedicine reimbursement parity with in-person services. This mandate applies to PERS for two years, then requires PERS to introduce legislation for it to apply to all payors in 2017. NDMA will be monitoring this bill to determine its effect on physician's practices.

WSI Issues: Workforce Safety and Insurance is currently undergoing an audit. After its completion, proposed legislation is expected with regard to independent medical exams, post-traumatic stress disorder, and opioid prescribing.

Tobacco Tax Increase: Pursuant to NDMA 2013's House of Delegates resolution in support of a tobacco tax increase, NDMA has joined a coalition to raise North Dakota's tobacco tax.

Assault against a Health Care Practitioner: NDMA has been requested to support the expansion of the assault law to include an elevated felony charge for assault against all health care practitioners in all settings.

This is only a preliminary agenda. The Commission will continue to meet prior to the start of the 2015 ND Legislative Assembly, fine-tuning the proposals above and likely adding items for consideration by the Council.

Federal Legislation

The Commission received updates on Medicare issues. The sustainable growth rate (SGR) formula is an enormous impediment to successful health care delivery and payment reforms that can improve the quality of patient care while lowering growth in costs. Physicians facing the constant specter of severe cuts under the SGR cannot invest their time, energy, and resources in care re-design. The first step in moving to a higher performing Medicare program is the elimination of the SGR formula. On March 31, 2014, the Senate passed H.R. 4302, the "Protecting Access to Medicare Act of 2014," which postpones the imminent 24 percent Medicare physician payment cut for 12 months, until April 1, 2015. The House passed an identical version of the bill by voice vote on March 27.

NDMA has been active on the federal level to communicate to our representatives about the implications of this cut, and the importance of repealing the SGR.

Other Legislative Activities

- ***NDMA PAC***
  The NDMA PAC Board will meet on October 8, 2014, to determine contributions to candidates for the current election cycle.

- ***Doctor of the Day 2015***
  The NDMA Doctor of the Day program was approved by the ND Legislative Council's interim Legislative Management Committee for 2015. NDMA will be encouraging all members to participate.

- ***Hospital/Physician Day***
  NDMA will be participating with NDHA on February 23 for a "Hospital/Physician Day" at the capitol. NDMA will be hosting this day with the North Dakota Hospital Association and the North Dakota EMS association. Specialty societies will also be invited to participate so the North Dakota "house of medicine" can be represented.

- ***Health Screenings***
  As in previous session, Altru Hospital is organizing a healthcare screening for legislators January 20-21, 2015.

Respectfully submitted,
Sarah L. Schatz, MD, Chair

Report of the Commission on Medical Services and Public Relations

Commission Members: Shari L. Orser, MD, Chair; James D. Brosseau, MD; Shiraz Hyder, MD; William N. Klava, MD; Timothy Mahoney, MD; Mary Ann Sens, MD; **NDMA Officers** ***(ex-officio members of all NDMA Commissions)*****:** Steven P. Strinden, MD; Debra A. Geier, MD; Fadel Nammour, MD; Misty K. Anderson, DO; A. Michael Booth, MD; Robert W. Beattie, MD; **Medical Students:** Brittany Azure, Rachel Fearing, and Amber Nielson.

The Commission on Medical Services and Public Relations is charged in NDMA's bylaws to "address public health and medical services issues and oversee NDMA public relations of NDMA, and act as a liaison with other organizations." The Commission met on one occasion since the 2013 Annual Meeting (August 28, 2014) to consider nominations for the Friend of Medicine Award and the Physician Community and Professional Services Award.

Respectfully submitted,
Shari L. Orser, MD, Chair

Report of the Commission on Socio-Economics

Commission Members: Parag Kumar, MD; Chair, Joseph E. Adducci, MD; Warren E. Albrecht, DO; Jayaram S. Bharadwaj, MD; Luis A. Garcia, MD; Shiraz Hyder, MD; Robert Riddick, MD; Robert McCartney, MD. **NDMA Officers:** Steven P. Strinden, MD; Debra A. Geier, MD; Fadel E. Nammour, MD; Misty K. Anderson, DO; A. Michael Booth, MD; Robert W. Beattie, MD; Shari L. Orser, MD. ; (*Officers are ex-officio members of all NDMA Commissions)*; **Medical Students**: Nathan Brunken, Craig Meiers and Zachary Fowler.

The Commission on Socio-Economics is charged in NDMA's bylaws to "address medical-economic issues, including insurance, third-party reimbursement and contracts, Medicare and Medicaid, and variety of other economic issues." The Commission met on one occasion since the 2013 Annual Meeting (September 10, 2014) to discuss health website ratings.

This issue was brought forth during the 2013 House of Delegates within Resolution 7:

Resolution No. 7

Introduced By: **First District Medical Society**

Subject: **Health Website Ratings**

1) **WHEREAS**, the internet has given unprecedented access to opinions/ratings both good and bad, and
2) **WHEREAS**, rating sites like www.healthgrades.com, www.doctorscorecard.com, www.doctorshelp.org, www.angieslist.com, www.ratemds.com, and the Better Business Bureau have patients post comments that are not verified, and
3) **WHEREAS**, these negative comments can hurt the reputation of practicing physicians, and
4) **WHEREAS**, physicians cannot retract these comments and do not have the knowledge or ability to dispute these comments, and
5) **WHEREAS**, since the internet has become interactive, meaning patients post negative feedback on these organic search engines, it can be very hard to clear the physician's reputation once an irate patient posts these comments. These comments can tarnish the physician's reputation, and
6) **WHEREAS,** whenever anyone conducts a physician search, these negative ratings show up on search engines and appear to be reputable.

THEREFORE, BE IT RESOLVED BY THE 2013 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION that NDMA submit a resolution to the AMA requesting that AMA act on this issue and develop tools to help physicians defend and restore their online reputation; and

BE IT FURTHER RESOLVED that NDMA refer this issue to the Commission on Socio Economics to explore the issues with online evaluations and critiques and support the membership in responding to online critiques.

Adopted October 4, 2013
Debra Geier, MD
Acting Speaker of the House

In accordance with the vote, the commission met. The Commission reviewed AMA's policy and the members came up with helpful action steps:

1. Physicians are regularly contacted by companies that offer to manage online reputations. NDMA will investigate these companies and offer information about these companies and determine which companies offer valid/worthwhile services, should any physician wish to enroll such services
2. NDMA will encourage all physicians to encourage their patients to post positive reviews online, if their experience was positive
3. NDMA will encourage all physicians to offer an in-office evaluation to patients, in order for physicians to identify areas that need improvement and areas of strength
4. NDMA will reach out to the membership to see how this issue has affected individuals in practice today
5. NDMA will research lawyers who are experienced in the realm of online reputation management, should any physician encounter a serious case of online slander and need legal representation

The Commission also discussed the various in-house evaluation processes taking place at hospitals and clinics around the state, as physicians are paid based upon the results of evaluations. Furthermore, the Commission discussed the 2014 Annual Meeting guest speaker, Trish Lugtu from MMIC, who is giving a presentation about managing online reputations. The Commission decided the presentation will be available to NDMA membership after the meeting so that those unable to attend the meeting can access the information and resources.

Respectfully submitted,
Parag Kumar, MD, Chair

Report of North Dakota Health Care Review, Inc.

North Dakota Health Care Review, Inc. (NDHCRI) is celebrating its 40 Year Anniversary in 2014. As a private, non-profit corporation, NDHCRI's mission is to improve health and healthcare for the people of North Dakota. The organization carries out its mission primarily by leading a wide range of statewide and local quality improvement initiatives. Significant changes have occurred, and more will continue to occur in the coming days and months. This includes a name change for NDHCRI, which will be announced soon!

CMS Medicare QIO Contract

This year the CMS Medicare Quality Improvement Organization program underwent significant changes. Under the newly redesigned program CMS has separated, reorganized, and regionalized many of the functions previously performed by state-based QIOs. Effective August 1, 2014, Medicare case review contracts were awarded to two national vendors known as Beneficiary and Family Centered Care QIOs (BFCC QIOs). These two vendors will cover review responsibilities in five newly created review regions. The vendor serving the region that includes North Dakota is KePRO, whose offices are based in Ohio.

CMS has awarded contracts to 14 Quality Innovation Network QIOs (QIN-QIOs) to lead statewide quality improvement initiatives over the next five years. NDHCRI, in partnership with QIOs in South Dakota, Nebraska, and Kansas, was awarded a QIN-QIO contract as the Great Plains Quality Innovation Network. Under this new QIN-QIO program and the Great Plains QIN, NDHCRI will have the continued opportunity to provide leadership for a variety of initiatives designed to improve safety and quality of care for North Dakota's Medicare beneficiaries.

Specific themes and topics that will be the focus of the new QIN-QIO 11th SOW include:

- Improving cardiac health and reducing cardiac healthcare disparities
- Improving diabetes care, diabetes self-management, and reducing diabetes healthcare disparities
- Improving prevention coordination through the meaningful use of HIT
- Reducing healthcare associated infections in hospitals
- Reducing healthcare acquired conditions in nursing homes
- Improving care coordination across health care settings and within communities
- Reducing adverse drug events
- Quality improvement through value-based payment, quality reporting, and the physician feedback reporting program

REACH, the HIT Regional Extension Center for North Dakota and Minnesota

Since 2010 NDHCRI has held a subcontract with Key Health Alliance, the HIT Regional Extension Center for North Dakota and Minnesota, providing technical assistance to eligible providers and hospitals for the adoption, implementation, and meaningful use of electronic medical records. Through July 2014, 521 North Dakota providers and 33 rural North Dakota hospitals have signed up for assistance under this program, and approximately 237 providers and 17 rural hospitals have achieved Meaningful Use-Stage 1.

NDHA/HRET Hospital Engagement Network (HEN)

Under a contract with the North Dakota Hospital Association, NDHCRI is providing quality improvement technical assistance to 34 North Dakota hospitals currently participating in the Hospital Engagement Network sponsored by HRET/AHA. Participating hospitals are collecting and reporting data on multiple quality indicators, and implementing changes to improve quality and safety and reduce harm.

The healthcare environment is rapidly changing, but there are some things that don't change, and that is our continuing partnership with the NDMA and many other collaborating organizations as we work towards the goal of providing outstanding healthcare for the people of our state.

Respectfully submitted,
Barbara Groutt, Chief Executive Officer

Report of the BCBSND Board of Directors

Doing business across North Dakota as Blue Cross Blue Shield of North Dakota (BCBSND), Noridian Mutual Insurance Company (NMIC) is a not-for-profit mutual company governed by a 13-member board of directors.

- BCBSND is one of 37 independent and locally operated Blue Cross and Blue Shield companies operating across the U.S. that, as independent licensees of the Blue Cross and Blue Shield Association and part of the Blue Cross and Blue Shield System, provide access for members to a nationwide and international network of participating doctors and hospitals.

- The company employs just over 3,400 at BCBSND and affiliated companies, with a majority of those working from Fargo offices as well as more than 500 working remotely or telecommuting.

- BCBSND provides personal service to members from nine offices across North Dakota.

- BCBSND provides health care coverage to more than half of North Dakota's population:

- Currently insures and/or administers claims for about 510,000 people.

- Enrollment in BCBSND health plans continues to grow, increasing from more than 505,000 members at the end of August, 2013 to almost 514,000 members as of July 31, 2014.

2013-2014, a year of industry challenges and change
All partners in the delivery and financing of health care have been part of unprecedented changes and challenges brought on the implementation of ACA, the rising cost of health care and our growing but aging population in North Dakota.

BCBSND experienced a $25 million underwriting loss in 2013. The loss was attributable to high cost claims and trends, ongoing issues related to the high cost of health care, the rollout of EMR systems and the resulting change in billing practices, and ACA implementation costs, which added an additional 3 percent to 2014 rates to cover ACA taxes and fees.

- From 2013 income of $1,195,644,000, claims incurred by members and paid totaled $1,108,368,000.

- Administrative expense for 2013 continued to be among the lowest among BCBS licensees, with approximately 93 cents of each premium dollar paid to health care providers for members' claims. BCBSND's percent of payments made out of premiums collected, called the medical loss ratio, exceeds the requirements set by the Affordable Care Act (ACA).

In mid-2014, the company's Board of Directors named a new President and Chief Executive Officer, Tim Huckle. Tim brings almost 30 years of BCBSND and health insurance industry experience to the organization and has implemented an ongoing strategy for long-term financial strength and stability on behalf of members and employees.

- Through two quarters in 2014, the BCBSND has increased its reserves and is working toward rebuilding financial strength through a number of administrative initiatives, careful management of our financial portfolio and diligent oversight of affiliates and investments.

Developing initiatives that support and reimburse quality and innovation
The quality of North Dakota's health care system continues to rank among the highest in the nation while BCBSND insurance rates rank among the lowest. Maintaining the balance between keeping premium rates affordable for members and providing adequate reimbursement for providers was made more difficult with the new challenges and requirements created by ACA.

- BCBSND is focusing on increasing collaboration and partnerships with providers, knowing that similar challenges are experienced by all.

- To facilitate greater collaboration with health care providers necessary in this new environment, BCBSND has also:
  - Reorganized the provider partnership team
  - Created a clinical quality committee to provide clinical input and feedback on quality programs under development

The focus on a transformation from "fee for service" to "outcome based reimbursement" continues. ACA requirements, Medicaid and Medicare are driving provider reimbursement models from volume to value. BCBSND provider initiatives in 2014 are building to the implementation of payment innovations in 2015:

- BCBSND continues to support primary care practices in their transformation towards a patient centered care model and health systems in their efforts to streamline all health care services.

- BCBSND's medical home program, MediQHome, was first piloted in 2009. Throughout 2014, the program is being streamlined to provide more value to providers.

- Through the Blue Cross Blue Shield Association's payment innovations program, BCBSND will be able to provide additional MediQHome care management fees for out-of-state Blue plan members starting in 2015. BCBSND is currently building the infrastructure to support this association initiative when it begins next year. Initial analysis shows this could result in an additional 73,000 members in MediQHome within North Dakota.

- Through a partnership with AIM Specialty Health, BCBSND has developed an advanced imaging review quality program. The AIM program provides the opportunity to improve care coordination for our members when receiving advanced imaging services.

- BCBSND's previous total cost of care program was designed for larger, integrated delivery systems and left many North Dakota providers without an opportunity to participate. What ACO model best serves BCBSND members will be determined through a collaborative discussion with the clinical quality committee.

- Employer groups are pressuring for the introduction of a telehealth solution. Understanding the importance of keeping health care local, the impact of draft legislation regarding telehealth, and the interest to collaborate for a local solution already expressed by North Dakota providers is driving the need to establish a long-term strategy.

Respectfully submitted,
Dale A. Klein, MD, Vice Chairman, NMIC Board of Directors
Greg C. Glasner, MD, NMIC Board Director

Report of the Midwest Medical Insurance Company Board of Directors

A REPORT TO THE NORTH DAKOTA MEDICAL ASSOCIATION

FROM BILL MCDONOUGH, PRESIDENT AND CHIEF EXECUTIVE OFFICER, MMIC

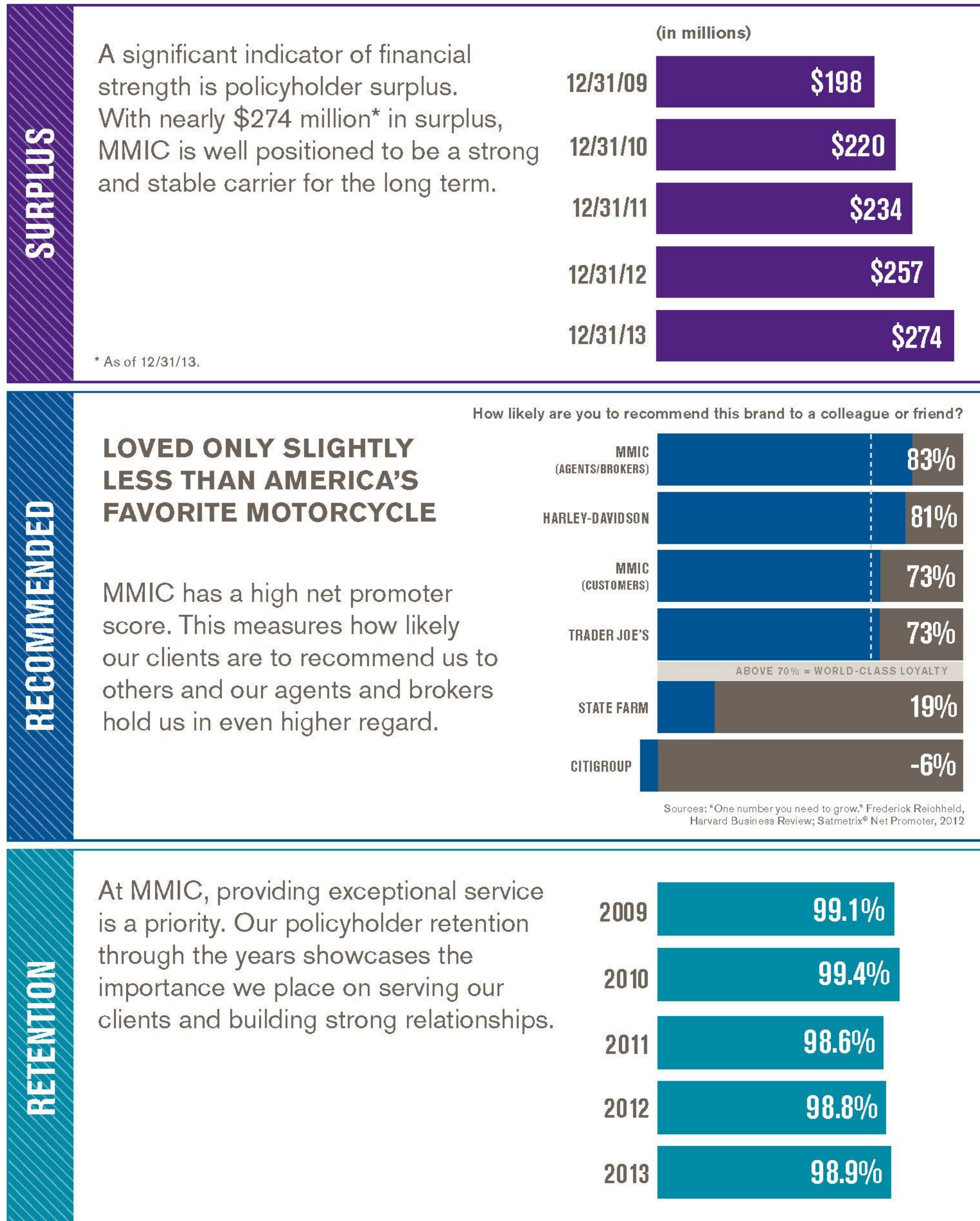
September 2014

I am pleased to submit this report to the North Dakota Medical Association to share our progress at MMIC. I am honored that the NDMA continues to partner with MMIC as its medical liability insurance carrier, and I look forward to many more years of partnership and the opportunity to serve North Dakota's physicians and health care professionals.

A look inside MMIC this past year reveals a common theme throughout our initiatives: partnership. We reached out to other companies and sources of expertise to add to our strengths, to expand our geographic footprint, and to augment our offerings. The result is a stronger, more effective whole.

Sharing information and resources is core to who we are as a company, and vital to how we fulfill our mission.

The past year was one of continued growth and collaboration for MMIC. At the end of 2013, we insured more than 17,500 health care professionals and more than 550 hospitals, clinics and outpatient and long-term care facilities.



We invite members of the NDMA to consider these additional measures of our company's performance:
SURPLUS
A significant indicator of financial strength is policyholder surplus. With nearly $274 million* in surplus, MMIC is well positioned to be a strong and stable carrier for the long term.
* As of 12/31/13.
(in millions)
12/31/09 $198
12/31/10 $220
12/31/11 $234
12/31/12 $257
12/31/13 $274
RECOMMENDED
LOVED ONLY SLIGHTLY LESS THAN AMERICA'S FAVORITE MOTORCYCLE
MMIC has a high net promoter score. This measures how likely our clients are to recommend us to others and our agents and brokers hold us in even higher regard.
How likely are you to recommend this brand to a colleague or friend?
MMIC (AGENTS/BROKERS) 83%
HARLEY-DAVIDSON 81%
MMIC (CUSTOMERS) 73%
TRADER JOE'S 73%
ABOVE 70% = WORLD-CLASS LOYALTY
STATE FARM 19%
CITIGROUP -6%
Sources: "One number you need to grow." Frederick Reichheld, Harvard Business Review; Satmetrix® Net Promoter, 2012
RETENTION
At MMIC, providing exceptional service is a priority. Our policyholder retention through the years showcases the importance we place on serving our clients and building strong relationships.
2009 99.1%
2010 99.4%
2011 98.6%
2012 98.8%
2013 98.9%

Highlights from the past year

One of the highlights for MMIC was the acquisition of UMIA Insurance, Inc., in July of 2013. UMIA is a Utah-based medical professional liability company with about 20 employees. Joining forces with UMIA enables MMIC to serve the medical community in four additional states in the Mountain West. Collaborating with UMIA has been a positive experience, and the successful integration of our companies will make our combined forces shine brighter together.

This partnership was made possible, in part, when MMIC and its holding company, Constellation, converted to a mutual structure just two years ago. Because of its affiliation with Constellation, now UMIA is also a mutual company.

Why does it matter that we are a mutual company? The distinction may not be immediately obvious, but I believe it's vitally important. Mutual companies serve policyholders, not shareholders in distant places. We make decisions that are in the medical community's best long-term interests, rather than being concerned about analysts who focus on quarterly share prices and growth.

Simply put, when an organization joins the Constellation family, its policyholders become part owners of the company. They hold a stake in a larger, financially solid entity whose singular focus is on serving its owners — the ones on the front lines delivering health care each and every day.

Constellation is the policyholders' company, located where they live and work. When medical professionals purchase a policy from us, they are investing in a company focused on their needs. There are no shareholders — only policyholder owners. Founded by physicians, our company continues to provide solutions for physicians to help address the risks inherent in health care. We do that by collaborating with our constituents to find new and better ways to assist with risk financing, patient safety, clinician well-being and information technology solutions.

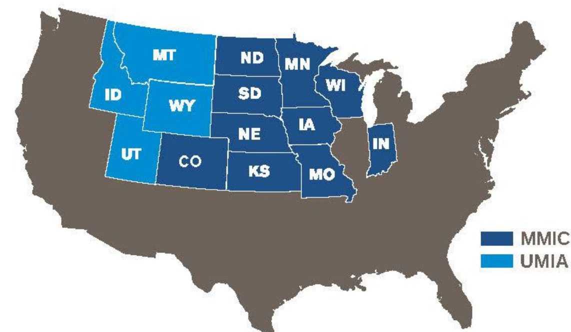
In 2014 and beyond, we will continue to join forces with like-minded organizations — those whose vision is to improve health care delivery industry-wide and positively shape health care for the long term. Collaboration is key to meeting the challenges of this dynamic health care environment. And improving the health care industry is good for all of us.

Additional Highlights

We'd like to highlight a few other initiatives from the past year.

To **SPREAD OUR MISSION**, we entered a new state.

In addition to adding four more states to our geographic footprint through the UMIA acquisition, MMIC is now doing business in Colorado, which brings the total number of states in our core territory to 14.



To **VALIDATE** our financial stability, A.M. Best affirmed our 'A' (Excellent) rating in 2014, for the 22nd consecutive year.

This strong rating demonstrates our ability to maintain a high level of financial stability while meeting our obligations to policyholders and expanding our reach.

To **HELP** health care providers navigate new challenges, we created or evaluated new clinical support tools.

We now offer PointClickCare,® an EHR for long-term and post-acute care facilities. To help lower the risk of missed or delayed diagnoses, we offer PeriCALM,® a tool designed to predict and reduce the incidence of shoulder dystocia and brachial plexus injuries during labor and delivery. And, we are evaluating VisualDx,® a visual diagnostic aid, and Isabel, a diagnosis checklist tool that can be integrated with electronic health records.

About a year ago we began collaborating with Harvard-based CRICO Strategies to mine claim data, then identify and find solutions for our clients' highest risk areas. We now have in hand the first crop of data pertaining to missed and delayed diagnoses, which we shared in our summer issue of *Brink*, our quarterly patient safety magazine for all policyholders.*

To **EXPAND** the availability of our patient safety tools and information for policyholders to use in their practices, we launched a new MMICgroup.com in June. The new site features a blog, a clinician well-being section, and more than twice the content — useful information for practitioners to apply to risks in their medical setting.

To **SERVE** you locally, we have the following MMIC representatives supporting you in North Dakota:

Account Executive

Kim Kanellis
402.384.5214

Claim Consultant

Tim Schultz
952.838.6746

Risk and Patient Safety Consultant

Leigh Ann Yates
952.838.6706

Underwriting

Karen Krier
952.838.6792

Amy Ward
952.838.6785

Thank you for the opportunity to tell you about our continuing efforts to collaborate with policyholders and the health care industry to make health care better for everyone. We look forward to another year of collaborating with the North Dakota Medical Association, our valued partner.

With warm regards,

[signature]

Bill McDonough

* If you haven't received your copy of *Brink,* write to Communications@MMICgroup.com to be added to our mailing list. Or access the PDF at MMICgroup.com.

Copyright 2014 by MMIC • All rights reserved. MMICgroup.com 1825 9/6/14

Robert W. Beattie, MD MMIC Board Member Representing NDMA

Report of the North Dakota Health Information Technology Advisory Committee on the North Dakota Health Information Network

North Dakota has established a Health Information Technology Advisory Committee (HITAC) to facilitate the adoption and use of health information technology and exchange to improve healthcare quality, patient safety and overall efficiency of healthcare and public health services in North Dakota. The HITAC consists of stakeholders appointed by the Governor, who represent providers, consumers, and trade associations, as well as representatives from the Governor's Office, the Legislature, ITD, Department of Health, and the Department of Human Services. The HITAC's vision is "Quality healthcare for all North Dakotans anywhere, anytime."

North Dakota was awarded a grant for the State Health Information Exchange (HIE) Cooperative Agreement Program from the United States Office of the National Coordinator for Health Information Technology (ONC) to build a sustainable health information network/exchange to be accessed by qualified organizations representing providers, physicians, hospitals, other health care organizations, and consumers.

The state health information exchange program promotes innovative approaches to the secure exchange of health information within and across state lines. This allows providers to have accurate and complete information about a patient's health, allow for better coordination of care, and provide information to help doctors diagnose health problems sooner, reduce medical errors, and provide safer care at lower costs. Additionally, the health information network offers options to providers and hospitals to meet Meaningful Use requirements in the Health Information Technology for Economic and Clinical Health Act of 2009 (the HITECH Act).

The State has contracted with Orion Health to implement the fully functioning, sustainable health information network to be accessed by qualified organizations representing providers, physicians, hospitals and other health care organizations. The program has been branded as the North Dakota Health Information Network (NDHIN) and offers two services.

NDHIN Direct Secure Messaging (DSM) is a simple, secure method to send encrypted health information directly to other known trusted users of DSM. Some examples of information that can be sent include documents, images, an HL7 message string, or a Continuity of Care Document.

The NDHIN query based services allows participants to use a robust bi-directional health information exchange to fully support meaningful use and health information technology. The robust exchange of health information, also known as query technology is another tool that a provider can use to push information to another entity, such as the North Dakota Immunization Information System.

The system can pull information from other providers needed to provide medical services to patients and display it in a clinical portal summarized for the user. The portal can include information such as allergies, past medical history, diagnostic results (labs and radiology), and immunizations and a user can query the prescription drug-monitoring program directly from the clinical portal. Future enhancements will include medication history and diagnostic quality images from several disparate PAC systems.

You can get involved in this endeavor by joining one of our workgroups; Technical Infrastructure, Finance, Legal and Policy, Clinical, Communication and Education, Tele-Health, and Data Use.

Information about the North Dakota Health Information Network can be obtained at http://www.ndhin.org or by contacting Sheldon Wolf at 701-328-1991 or at shwolf@nd.gov.

Respectfully submitted,
Sheldon Wolf, Director
ND Health Information Technology

Report of the North Dakota Medicaid Drug Utilization Review Board

The North Dakota Medicaid Drug Utilization Review Board was implemented about 10 years ago. Its charge is to oversee policy, procedures and the budget for the administration of the formulary for North Dakota Medicaid. Its members consist of several physicians, including an NDMA representative, several pharmacists from both hospitals and commercial pharmacies, a pharmaceutical industry representative and one non-medical community representative. The Board meets quarterly, usually at the state capitol. The meetings are open to the public and generally attended by a large contingent of pharmaceutical representatives. The staff for the Board is Brendan Joyce Pharm D and Candace Reith Pharm D.

The DUR Board has generally been credited with doing much to reduce pharmaceutical spending by Medicaid during its existence. The expiration of patents on drugs such as Lipitor, Plavix and Prozac definitely helped this happen but the policies put in place have also helped this along. Currently, 80% of North Dakota Medicaid's prescriptions are written for generic drugs.

The budget for Medicaid's formulary is ultimately the responsibility of the Legislature, but its status is routinely presented at each meeting.

Coverage policies and procedures for individual drugs typically dominate the agendas. By law, Medicaid must cover any FDA approved drug. Cost is a major concern and clearly guides much of the decision making. Generics in general are covered without any restrictions as they tend to be lowest cost. Oddly, a provision in the Affordable Care Act established a system of rebates from the manufacturers to the state Medicaid programs which basically freezes prices of certain drugs that were not generic in 2010. This has resulted in some anomalies in coverage policies where certain brand name drugs may receive coverage in spite of a high published wholesale cost. These rebates, by law, may not be disclosed to the public, and are split between the feds and the state in proportion to each entity's support of the Medicaid program. One kicker: under ACA, the feds have begun to increase their portion of the rebate, ostensibly to fund Medicaid expansion. Yes, that means even the state of North Dakota is being taxed to pay for Obamacare.

Typically, to control costs and utilization, Medicaid will decide whether or not to require prior authorization before approving payment for a given drug. By law, certain classes of drugs, such as anti-neoplastics, cannot be restricted in this manner. Most generics also do not require pre-authorization. When a new brand-name drug is introduced and prior authorization is deemed appropriate, Medicaid may require that other class-similar drugs first be tried and deemed ineffective or not tolerated before approving the new drug. In some instances, such as drugs being used to treat Hepatitis C, Medicaid may require the involvement of a specialist before approving payment.

The DUR Board also oversees utilization patterns. Prescription narcotics not surprisingly have received considerable ongoing attention. A fairly detailed protocol for prior authorization of many of these drugs has been developed. Data on physician prescribing patterns are monitored as well as patient consumption of these drugs. Suspected criminal patterns have been observed from time to time and reported to law enforcement. There has been some discussion about requiring providers to query the state's Prescription Drug Monitoring Program (PDMP) prior to writing prescriptions. Due to problems with the PDMP software and also anticipating much better penetration by fully-functional EMRs in the next few years, no action has been taken to date to push this any further.

North Dakota's Medicaid expansion also has received some attention from the DUR Board. This expansion was actually not included under the general Medicaid program. Rather, it has been contracted out to Sanford Health,

which is independently managing the pharmaceutical benefits. As a result, this may result in some inconsistencies in coverage which may require action going forward.

Overall, the Board seems to be doing a good, albeit somewhat tedious, job.

Respectfully submitted,
A Michael Booth MD PhD
NDMA Representative

The North Dakota Medicaid Drug Utilization Review Board (DUR) continues to meet quarterly. The members of the committee continue to be well-balanced mix of physicians, pharmacists, and patient advocates appointed by the governor. Some brief highlights of the topics covered during these meetings:

- All new pharmaceutical agents that came on the market were reviewed and criteria for appropriate use were discussed and adopted with the emphasis being on ensuring that patient care concerns remain the foremost priority.
- Drug costs, which also are a priority in the current medical and political environment, continue to be monitored with development of strategies to help providers give the most cost-effective therapy for the over 60,000 North Dakota Medicaid patients while ensuring quality of care and access to necessary medications.
- The North Dakota Department of Human Services NDC Drug Lookup has been updated to allow users to search for a drug by name or NDC number, and has a link to each drug's required Prior Authorization form. This application can be found at http://nddruglookup.hidinc.com.
- Smoking cessation medications continue to be covered for Medicaid patients as long as they are involved in a smoking cessation program through the NDQuits Program.
- Finally, the DUR board continues to review and give recommendations to Medicaid about its provider education program that includes the therapeutic alerts that are sent to providers.

The North Dakota Medicaid Drug Utilization Review Board and its members along with the dedicated Medicaid pharmacy staff endeavor to make medication therapy as effective and as easily available to patients and providers as possible. Feedback and suggestions from providers and patients is always appreciated.

Respectfully submitted,
Jeff Hostetter, MD
NDMA Representative

Report of the North Dakota Medicare Carrier Advisory Committee

As you may have noticed Noridian Administrative Services has changed names to Noridian Healthcare Solutions. The core Medicare team has not changed.

Over the past few months Noridian has been privileged to continue to provide our Medicare providers with stellar service. As medicine continues to evolve we continually review our procedures and policies to keep up with the changes in medical knowledge and technology so that you can provide the best, evidence based care to the Medicare beneficiaries in North Dakota.

In keeping with updated services Noridian has amended or implemented the following Local Coverage Determinations:
Flow Cytometry
Intensity Modulated Radiation Therapy (IMRT)
Mohs Micrographic Surgery
Non-Covered Services
Drugs of Abuse Laboratory Testing (Final still pending)
Nerve Blocks for Neuropathy et al
Percutaneous Vertebral Augmentation

The following LCDs will be presented at the September CAC*:
CYP Genetic Testing
MolDx Breast Cancer
MolDx Prostate Cancer
Erythropoietin Stimulating Agents
Blepharoplasty
Ulcers and Symptomatic Hyperkeratosis

*All such policies are reviewed by your peers and by the respective national specialty societies to make sure they reflect the latest up to date knowledge base. You and your members may also submit comments during the LCD comment period.

We are pleased to note a decrease in our CERT error rate thanks to you and your staff's help in providing the CERT contractor with proper records and signatures. Please remember to respond to any CERT contractor request for records in a timely manner. We continue to address these issues and greatly appreciate your cooperative spirit in addressing such issues. Should you have any questions regarding CERT or a particular request please contact Noridian's Part B CERT Coordinator, Patty Holton, RN at 701.433.5969 or by email (NO PHI but CERT reference number alone is ok) at CERTQuestion@noridian.com.

We encourage each of you to have someone in your practice sign up for the Noridian Medicare email listserv. This venue provides the latest updates from CMS and Noridian. It is perhaps the best means of keeping current on what is happening that may affect your practices.

Lastly many of you know or have worked with Dr. Bernice Hecker. Dr. Hecker has chosen to retire from Noridian at the end of 2014. We will greatly miss her and wish her the best in her future endeavors.

Respectfully submitted,
Gary Oakes, M.D.
Contractor Medical Director
Noridian Healthcare Solutions LLC, Fargo

Report of the North Dakota Prescription Drug Monitoring Program Advisory Committee

The NDPDMP Advisory Committee met November 13, 2013. During the meeting progress reports were presented which has shown increased participation by both prescribers and dispensers. The project of integrating the Prescription Drug Monitoring Program information with the North Dakota Health Information Network (HIN) was initially discussed with the advisory council. The Advisory Council were very supportive of the project. This connection is live and actively working in a way that the user can access a patient's PDMP report directly within the HIN connection with the various health systems in which are integrated. The changeover in the PDMP vendor to the current Appriss system was initially discussed with the council. This software change was implemented on April 2nd 2014. This system gives practitioners a much more user friendly software platform to search patients and view a prescribers own prescribing history.

The PDMP Advisory Council also met on April 17th, 2014. The majority of the meeting included a presentation from a representative from Appriss which operates the PDMP software. The new software system is called PMP AWARxE. The Advisory Council received information on how the system operates, how searches and matches are done, and future enhancements to the program that will benefit the PDMP and its users. All members seemed happy with the functionality of the system and felt that it was a big improvement over the previous software system. The Advisory Council heard more about the integration project with the Health Information Network and made recommendations on future partners for integration of the PDMP into electronic health records. The Council discussed the reducing narcotics task force in which many stakeholders have been participating. In these meetings, the discussion has been initiated from legislators looking at criteria to require practitioners and pharmacists to check the PDMP under certain circumstances before prescribing or dispensing a controlled substance medication.

PMP Interconnect (PMPi) is a communication hub that will, for participating PMPs, facilitate the transfer of PMP data across state lines to authorized users. Since August 1, 2014 the PDMP is now connected to 18 other states in the PMPi hub database, including two of our bordering states, Minnesota and South Dakota with the hopes of Montana joining the hub sometime in 2015.

The PDMP Council consists of a member of a designee of the Board of Pharmacy, Medical Association, Board of Nursing, Attorney General, Department of Human Services, of the Board of Medical Examiners and ND Nurses Association. The purpose of the Advisory Council is to advise and make recommendations to the Board of Pharmacy on how to best direct the program and improve patient care. Also by fostering the goal of reducing the misuse, abuse, and diversion of controlled substances and to encourage coordination among all involved.

The next scheduled meeting is in October 2014.

Respectfully Submitted
Sarah McCullough, MD
NDMA Representative

Kathy R. Zahn, Program Administrator
Prescription Drug Monitoring Program
North Dakota State Board of Pharmacy
1906 E. Broadway Ave. Bismarck, ND 58501
24 Hour Support: (855) 563-4767 Ph. (701) 328-9537 Fax. (701) 328-9536

Report of the North Dakota State Board of Medical Examiners

Board:
Gaylord Kavlie, MD, Chair Bismarck
Kent Hoerauf, MD, Vice-Chair Hettinger
Kate Larson, PA-C, Treasurer Garrison
Thomas Carver, DO, Minot
Manuel Cólon, MD Fargo
Genevieve Goven, MD Valley City
William Haug, Jr., MD Grand Forks
Kent Martin, MD Bismarck
Robert J. Olson, MD Fargo
Burt Riskedahl Bismarck
Sara Solberg, MD Williston
Kayleen Wardner Dickinson

Staff:
Duane Houdek, Executive Secretary
Lynette McDonald, Deputy Executive Secretary
Marijo DeMott, Physician Assistant and Resident Licenses, Physicians Health Program and Continuing Medical Education
Lynn Schreiner, Credentialing

Licenses: (2014 2nd Quarter)
The Board licenses 3,759 physicians, 325 physician assistants, six genetic counselors, and six fluoroscopy technicians. Of the 3,759 licensed physicians, 1,882 practice within the state and 1,877 practice outside the state, but their practice includes North Dakota citizens as patients or otherwise requires a license.

As of July 31, the following licenses were issued by the board in 2014:
Physicians:
- Permanent: 257
- Provisional temporary: 231
- *Locum tenens:* 23
- Administrative: 6
- Special: 2
- Resident: 48

Physician Assistants:
- Permanent: 34

Genetic Counselors: 6

North Dakota Professional Assistance Program
The board is pleased to announce the formation of the North Dakota Professional Assistance Program, a health program for the board's licensees that facilitates the treatment and rehabilitation of substance abuse disorders and mental and physical health issues.

For the past 20 years, the board itself has operated a confidential physician health program to address physician health issues, based on a successful and proven model that includes a long term (five year) commitment, testing and monitoring in substance abuse cases, participation in aftercare programs, involvement of a treating physician and quarterly reporting of health issues to the board.

In 2013, the board sought legislation that would allow the formation of an independent entity that would continue the program, and enhance it through the addition of dedicated medical and clinical staff. Importantly, it was felt the separation of the program operation from the licensing board would make it easier for the family and colleagues of physicians and physician assistants with health issues to make confidential referrals earlier in the disease process, before there was a threat of impairment.

The safety of the public will be maintained by the assurance that any practice-related violations will be reported promptly to the medical board, and strengthened through earlier identification, intervention and treatment of potentially impairing conditions. The NDPAP will be a member of the Federation of State Physician Health Programs.

The founding board members of the NDPAP include Kurt Snyder, chair, Bismarck; John Olson, Bismarck; Clara Sue Price, Minot; Lois Delmore, Grand Forks; Lance Schreiner, Bismarck; Dr. Andrew McLean, Fargo; Dr. Dennis Wolf, Dickinson; and Dr. Julie Blehm, Fargo. The NDPAP has hired Tammy King as its executive director and Dr. Barrie March as its medical director. It plans to be operational by September 2, 2014.

Contact the Board:
For all forms, including license applications and complaints, and for all laws governing license eligibility and the operation of the Board of Medical Examiners, please visit our website: www.ndbomex.org

General inquiries may be directed to:
North Dakota State Board of Medical Examiners
418 East Broadway, Suite 12
Bismarck, ND 58501
Phone: 701/328-6500
Email: lmcdonald@ndbomex.org

Report of the North Dakota State Health Officer

Greetings! I am pleased to provide an update about North Dakota Department of Health (NDDoH) activities and some of the issues the department has been addressing since my last report to this association.

Hepatitis C Outbreak
In the fall of 2013, the NDDoH discovered an outbreak of hepatitis C in an elderly population in Ward County. As of the end of July, 2014, 47 cases have been tied by quasispecies analysis to the outbreak. The first 45 cases were either residents or former residents at a single care facility. The last two cases were discovered in residents of a different care facility and did not have a history of residency at the first care facility.

The NDDoH has worked with local public health personnel and the health facilities affected by the outbreak to test those in the area who may have been exposed, and to review and reinforce infection control protocols at all facilities and across disciplines. The scope of our testing and our reinforcement of infection control protocols has expanded to all care facilities within Ward County. In approximately 30 percent of hepatitis C outbreak cases, the cause of the outbreak is not definitively identified; however, studies show that increasing vigilance regarding infection control will work to stem the spread of the outbreak.

The NDDoH continues to investigate this outbreak.

Diseases
We continue to work to increase the vaccination rates within the state. Some of the numbers are very good in North Dakota, but others, such as the rate of HPV vaccinations, lag behind the national average.

The NDDoH has also been involved in investigating and responding to other diseases over the past year.

Syphilis numbers indicate an outbreak in the area of Sioux County in south central North Dakota. Several congenital cases have been identified. NDDoH is working with local officials to identify, interview and treat affected individuals, and has sent out several HAN alerts to medical providers to be aware of the outbreak and ramifications it might have for their patients.

Other STD numbers are rising across the country, and North Dakota is no exception. We are working to increase educational efforts regarding prevention to both medical providers and the public.

West Nile is still prevalent in the state and we continue to monitor this virus.

We identified a cluster of tularemia out of the Ramsey County area; this was a rare outbreak.

North Dakota has experienced one Hantavirus death in 2014.

The 2013-14 influenza season was rather mild, with H1N1 being the predominant form of influenza reported. 54 pneumonia and influenza deaths were reported during the 2013-14 influenza season. Vaccinations were readily available during the flu season.

The Ebola outbreak in West Africa has not directly affected North Dakota as of this writing, but the department has been pro-active in addressing the possibility of a diagnosis within our state by holding conference calls with our partners in the health care industry, along with the university system, businesses and the general public. We have worked to pre-position supplies and prepare local public health units in the event of a suspected or confirmed case.

Oil Activity
Oil activity in the state continues to proceed at a rapid pace, and while some infrastructure issues seem to be catching up, we are still feeling the effects of a dramatically increased workload.

With an increase in oil activity and pipeline construction, we have seen an increase in reports of spills, fires and other events that might affect public health. Our Environmental Health Section has worked diligently to make sure we have inspectors and other experts available to address these events. One of the topics of interest has been the regulation and disposal of TENORM within the state. TENORM is a by-product of the fracking process that consists primarily of low level radioactive waste, often collected in "socks." The NDDoH has commissioned a study to determine whether TENORM disposal rules in the state should change. We expect to have a final draft regarding TENORM available for public comment in the fall of 2014.

Our Food and Lodging Division has been impacted by development in the western part of the state. We perform more inspections of temporary housing and new and existing food establishments to make sure regulations are being followed and public health is protected.

The department, along with other state agencies and our local partners, continues to collaborate regarding issues of change and population growth in oil country. One way we do this is by participating in an oil development work group that includes local public health units from western areas.

Emergency Responses
Our Emergency Preparedness and Response Section has provided support to various hospitals and other care facilities over the course of the year. For example:

- In December 2013, we provided support for the train derailment and explosion in Casselton.
- In February 2014, we worked with health facilities in the Red River Valley after a pipeline explosion in Canada threatened the heating supply for those facilities.
- We provided heating and cooling support for facilities that experienced problems with those systems.
- We also sent assets to assist in the monitoring and clean up after the Red River Supply fire in Williston in July 2014.

Grand Forks Area Tuberculosis Outbreak
In 2013, there were 12 cases of active tuberculosis (TB) reported in North Dakota. Cases linked to an outbreak that occurred in Grand Forks County continued to be reported. Two cases from 2010, along with an additional five in 2013, are also linked to the outbreak, bringing the total number of cases to 29. Additionally, more than 80 cases of latent TB infection have been identified through case investigations. More than 1700 contacts have been tested thus far. The North Dakota Department of Health, Grand Forks Public Health, Altru Health System and other local partners continue to work together throughout the outbreak to conduct case investigations, ensure cases receive care and follow recommended treatments, and communicate with the public and targeted audiences.

We extend a thank you to all agencies who have helped and continue to help respond to this outbreak

2015 Legislative Session
The NDDoH has prepared budget requests designed to continue and increase our ability to meet the changing public health needs of our state for the next biennium. Although these requests have not been finalized as of this writing, we hope to see an increase in the number of FTE positions to enhance the capabilities of the sections that have been most impacted by oil development.

Respectfully submitted,
Terry Dwelle, MD, MPHTM
ND State Health Officer

Report of the North Dakota State Trauma Committee

Summary

1. North Dakota's trauma system is very well run and highly regarded nationally.
2. ND has thorough trauma review and quality improvement processes in place and one of the best trauma tracking databases nationally.
3. Increased demands across western ND continue to strain services. *(See below for discussion).*
4. Hospitals in the trauma network are reviewed periodically and all reviewed institutions have maintained their trauma designation.
5. Committee is offering the Rural Trauma Training Development Course (out of the state trauma budget) for interested facilities, but scheduling issues have limited participation thus far.

Discussion

North Dakota has a well-run, well-funded, and well-regarded trauma system in place. There are continuous quality improvement initiatives in place as well as ongoing review of each institution's performance. In general, hospitals across the state meet or exceed most trauma care standards. No hospitals have lost their trauma designation due to severe deficiencies.

Increased demand for services, particularly in western North Dakota, has placed a strain on EMS, air transport, hospitals, and health care workers. One item in particular that may be of interest to the NDMA is Mercy Medical Center's (Williston) push to amend the state trauma bylaws and allow board-certified emergency medicine physicians to be the attending physicians in trauma cases without current certification in Advanced Trauma Life Support (ATLS).

The American College of Emergency Physicians' policy is that EM physicians take ATLS during residency and have continued exposure to trauma cases and thus should not have to recertify in ATLS. North Dakota requires current ATLS certification to be the attending provider in a trauma case (at a level 4 and 5 trauma center). Mercy's position is that this impairs their ability to recruit locum tenens EM physicians as many of them follow the ACEP recommendation that ongoing ATLS certification is not necessary.

The State Trauma Committee voted against amending the bylaws to allow board-certified emergency medicine physicians to attend traumas. However, the physicians on the committee did vote in favor of amending them. The rest of the committee thought that ATLS recertification was not onerous and was a good refresher in trauma systems (i.e. transfer of severely injured patients). It was also discussed that Mercy could recertify as a Level 3 trauma center which would obviate the ATLS requirement.

This issue may resurface during the legislative session as the state legislature could change those bylaws. I suspect that the legislature would be supportive of this change, particularly if a representative from Mercy were to testify. There was no representative to testify at the state trauma meeting, so we could not get a true measure of the hardship this rule causes.

The committee would accept the change if the legislature acted upon this. My opinion, shared by the other physician members of the committee, is that this would not significantly change trauma care in North Dakota and likely be utilized in only a few instances. It would simply shift the responsibility to each hospital's privileging process to determine the standards for their providers.

The NDMA may be asked to weigh in upon this. My recommendation would be in favor of changing the bylaws to allow board certified emergency medicine physicians to attend trauma cases in Level 4 trauma centers. This is based on the presumption that current EM practice, maintenance of certification, and ongoing board certification are reasonable surrogates for ATLS. It could also be mentioned that a thorough evaluation should still be done by each hospital prior to granting privileges.

Respectfully submitted,
Joshua C. Ranum, MD
NDMA Representative, State Trauma Committee

Report of the North Dakota Tobacco Prevention and Control Advisory Committee

The following report reflects progress made in the past year in reaching the goals of *Saving Lives – Saving Money, North Dakota's Comprehensive State Plan to Prevent and Reduce Tobacco Use*. This plan is required by the N.D. law that mandates about 20% of the state's settlement with tobacco companies be used for the settlement's intended purpose: tobacco settlement for tobacco prevention. Three-fourths of the comprehensive tobacco prevention program is funded by the agency established to administer this program, the N.D. Center for Tobacco Prevention and Control Policy. One-fourth is funded by the N.D. Department of Health.

The Center is governed by a 9-member Advisory Committee appointed by the Governor, including one medical doctor appointed from three names submitted by the N.D. Medical Association. Currently, Dr. Eric Johnson, Grand Forks, serves in this capacity.

This state plan follows the current science translated into best practices in *CDC Best Practices for Comprehensive Tobacco Control Programs 2014*, showing population-wide policy work at the state and community levels is most effective in cutting tobacco use rates. Local policy work is undertaken in your communities by your local public health unit and statewide organizations funded by the Center. The state plan has 4 goals and numerous policy objectives all intended to make tobacco-free lifestyles the norm for N.D. citizens.

Here is a very brief synopsis of the work done from July 1, 2013 – June 30, 2014. Check us out: www.breathend.com .

Goal 1: Prevent the Initiation of Tobacco Use Among Youth and Young Adults
Cigarette excise tax: Since 1993, North Dakota's tobacco excise tax is 44 cents/pack, now the 46th lowest of 50 states, well below the $2.02/pack average tax in the three surrounding states. Our youth smoking rate is 19%; the national average is 15.8%. Raising the tobacco tax is one of the strongest evidence-based polices to reduce use for youth and adults. If the N.D. Legislature would the increase the tobacco tax to $2/pack, it would reduce youth smoking by 25%, bringing North Dakota's youth smoking rate to 14%. This has been an unmet objective since 2009. The statewide Raise It For Health ND coalition is ready to work with the 2015 legislation increase the tax to $2/pack for health.

Electronic cigarette youth access ordinances: E-cigarettes are unregulated nicotine delivery devices with no federal or state law regarding minimum age for purchase, no taxing as a tobacco product, no child-proof packaging, no requirements for license to sell, and no restrictions on self-service purchases. Local public health units and their coalitions have been successful in protecting nearly one-third of our youth who live in 11 cities that passed ordinances prohibiting e-cig sales to minors. (Cities are Fargo, Bismarck, Williston, Mandan, Wahpeton, Hankinson, Minot, West Fargo, Langdon, Crosby and Grand Forks.) Seven of these communities also restrict self-service merchandizing or displays and two have e-cigarettes licensed as tobacco products. A bill is being drafted for consideration during the 2015 legislative session to prohibit e-cig sales to minors, prompted by a middle school SADD chapter sharing information with a state representative about how easy access to e-cigs impacts middle school students.

Tobacco Free Schools/Post-secondary Campuses: Fifteen public, private or BIA schools adopted comprehensive tobacco-free campus policies this year. 138 out 224 K-12 school districts now have verified comprehensive tobacco-free campus policies. Williston State College and United Tribes Technical College adopted tobacco-free campus policies, bringing the total number of tobacco-free higher ed campuses to 14.
www.breathend.com/news/detail.asp?newsID=334

Goal 2: Eliminate Exposure to Secondhand Smoke
Multi-unit housing: The work continues on policies/ordinances/laws that restrict exposure to secondhand smoke and tobacco use in indoor areas, like multi-unit housing, not covered by N.D. Smoke-free Law. One public housing smoke-free policy verified this year affected 70 buildings and 452 units. Altogether this past year, local public health units reported 280 apartment buildings, condos, or townhouses were smoke-free properties.

Goal 3: Promote Quitting Tobacco Use
Health System Changes: The implementation of electronic health records has aided local public health units in their work in this area. Local public health units reported 7 health care providers adopting the Public Health Service Guidelines to Ask about tobacco use, Advise to quit, Assess readiness, Assist in quitting and Arrange follow-up for tobacco users at every clinical visit. In addition, 87 presentations to 719 people were conducted on the 5 A's. The N.D. Department of Health's Million Hearts S Grants in some health care systems promotes the 5 A's, with continued work to add reminder systems, annual auditing of records for quality improvement, and systematic orientation of new staff. The current state plan includes work with mental health and substance abuse facilities to encourage these providers to have tobacco-free campus and tobacco treatment policies so tobacco addiction as part of all treatment.

NDQuits: The N.D. Center for Tobacco Prevention and Control Policy has granted $142,110 to local public health units for local cessation efforts including NRT, advertising of NDQuits, and personnel for quit classes.

Goal 4: Build Capacity and Infrastructure
Health Communications (public education): The N.D. Center for Tobacco Prevention and Control Policy funds ads on TV and radio, and ads in weekly newspapers statewide to educate the public on: secondhand smoke exposure, societal costs of tobacco, tobacco industry targeting of youth, how price of tobacco affects use (especially with youth) and tobacco's impact on chronic disease. Public education is also provided through digital and specialty print ads, state and local websites, newsletters, and news releases, resulting in a high level of public support for current laws and additional laws and policies.

The state law that established an agency, governing body, and tobacco settlement dollars for a trust fund for a comprehensive program: NDCC 23.42.01-07, NDCC 54.27.25.

The state law that established smoke-free public and work places: NDCC 23.12.09-11.

Current statutes became law through passage of voter-initiated statewide measures placed on the ballot in 2008 (comprehensive program) and 2012 (smoke-free places).

For more information, contact the N.D. Center for Tobacco Prevention and Control Policy, or see www.breathend.com .

Respectfully submitted,
Eric L. Johnson, MD
NDMA Representative

Report of the University of North Dakota School of Medicine and Health Sciences

Education

- Class size expansion fully implemented under the Healthcare Workforce Initiative (HWI)
  - A total of 16 additional medical students/year
  - A total of 30 additional health sciences students/year
- Residents slots added under Phase I of the HWI
  - Rural family medicine
  - Rural surgery
  - Hospitalist
- Additional residency slots recently approved under Phase II of the HWI
  - Rural psychiatry
  - Geriatrics fellowship
  - OB/GYN
  - Feasibility study of additional rural family medicine training
- Medical School class of 2018
  - Largest in school history with 78 students (including 7 Indians into Medicine)
  - 85% from North Dakota
  - Average GPA 3.68
- Financing of medical education
  - UND SMHS tuition lowest of comparison institutions
  - 18 students currently enrolled in RuralMed scholarship program, with 8-10 likely additional enrollees
- New building construction on time and on budget
  - Estimated opening summer of 2016, just in time to welcome the incoming medical school class of 2020
  - For updates, live webcam, and other information regarding the new facility: http://www.med.und.edu/construction/index.cfm

Research

- Submitted grant requests for the past year totaled $80.3M
- Funded grants totaled $20.7M, reflecting a remarkable funding rate of 26%
- Research funding has been growing despite a bleak environment for federal funding
- The SMHS is the only school/college within UND that has experienced an increase in external sponsored funding over the past four years
- We have received funding for three multi-million dollar collaborative federal grants to build the research infrastructure at UND and North Dakota

Service

- UND SMHS again recognized by the American Academy of Family Physicians (AAFM) for being #1 in the country as to the percentage of its graduating class going into family medicine
- UND SMHS recognized by U. S. News and World Report as #2 in the nation (tied with the University of New Mexico) for preparing students for a practice in rural communities
- Indians into Medicine (INMED) program continues to prepare, support and educate seven American Indian medical students each year
  - INMED is responsible for educating one out of five American Indian physicians across the United States!

- Center for Rural Health (CRH) continues to grow as it supports rural healthcare delivery in North Dakota and rural America
- The School continues to emphasize interprofessional education as a key component to improve the healthcare delivery system
  - The creation of physical space in the new building in the form of "Learning Communities" will further support and develop this collaborative care model
- Master of Public Health (MPH) program continues to grow and prepare graduates to address population health challenges as a way to improve health, reduce disease burden, and improve the quality of life

Administration

- Dr. Tom Mohr named Associate Dean for Health Sciences, and Dr. David Relling named Chair of the Department of Physical Therapy
- Dr. Jau-Shin Lou named the Roger Gilbertson, M.D. Chair of Neurology at UND SMHS and Sanford Health
- There is active recruitment for several other positions; all are progressing favorably
  - Associate Dean for Medicine
  - Associate Dean for Education
  - Chair of Population Health
  - Senior Scientist, Epigenetics program

Respectfully submitted,
Joshua Wynne, MD, MB, MPH
Dean, UND SMHS

Resolution No. 1

Introduced By: **NDMA Council**

Subject: **Interstate Licensure Compact**

1 **Whereas**, medical licensure can be a cumbersome and time-consuming process for physicians
2 practicing in or moving among multiple states; and

3 **Whereas**, improving the efficiency and time required to license a physician can expedite placement
4 of a physician who is needed to care for patients especially in high demand practice and shortage
5 areas; and

6 **Whereas**, an interstate physician licensure compact could positively impact the mobility of
7 physicians in meeting patient demand for access to healthcare; and

8 **Whereas**, the Federation of State Medical Boards developed an Interstate Medical Licensure
9 Compact, that complements the existing licensing and regulatory authority of state medical boards,
10 provides a streamlined process that allows physicians to become licensed in multiple states, thereby
11 enhancing the portability of a medical license and ensuring the safety of patients; and

12 **Whereas,** the Compact creates another pathway for licensure and does not otherwise change a state's
13 existing Medical Practice Act; and

14 **Whereas,** the Compact also adopts the prevailing standard for licensure and affirms that the practice
15 of medicine occurs where the patient is located at the time of the physician-patient encounter, and
16 therefore, requires the physician to be under the jurisdiction of the state medical board where the
17 patient is located; and

18 **Whereas**, state medical boards that participate in the Compact retain the jurisdiction to impose an
19 adverse action against a license to practice medicine in that state issued to a physician through the
20 procedures in the Compact; and

21 **Whereas**, to become a member state of the Compact, the Interstate Medical Licensure Compact
22 must be adopted by the state legislature.

23 **Therefore, Be It Resolved By the 2014 House of Delegates of the North Dakota Medical**
24 **Association** that NDMA encourage the North Dakota Board of Medical Examiners to consider and
25 propose adoption of the Compact in the 2015 North Dakota Legislative Session.

Resolution No. 2

Introduced By: **ND Chapter of American College of Emergency Physicians**

Subject: **Assault Against a Health Care Provider**

1 **Whereas**, the American Medical Association supports increased protection against violence toward
2 healthcare providers, including the apprehension and prosecution of persons who commit acts of
3 assault on healthcare providers performing in a professional capacity; and

4 **Whereas**, the increase in population in North Dakota has brought an increase in crime and assaults
5 in the workplace against health care providers; and

6 **Whereas**, violence in a healthcare setting is becoming more widespread, accounting for 60% of
7 workplace assaults; and

8 **Whereas**, current North Dakota Law provides for Class C Felony classification for assault against
9 an emergency department worker in the performance of the member's duties; and

10 **Whereas**, these additional protections should be extended to all health care providers engaged in
11 official duties.

12 **Therefore, Be It Resolved By the 2014 House of Delegates of the North Dakota Medical**
13 **Association** that the North Dakota Medical Association seek legislation that provides for a class C
14 felony assault classification when a person willfully or negligently causes physical injury to a
15 healthcare provider when the person knows or has reason to know that the victim is a healthcare
16 provider engaged in official duties.

Resolution No. 3

Introduced By: **NDMA Council**

Subject: **Safe Injection Practices**

1 **Whereas,** the use of safe injection practices through the use of sterile techniques is a fundamental
2 obligation of healthcare practitioners in the protection of patients against the transmission of
3 infectious disease; and

4 **Whereas,** the failure of healthcare practitioners in North Dakota to utilize safe injection practices
5 have been proven to result in the transmission of infectious disease; and

6 **Whereas,** the impact on individuals who were infected has been severe, the confidence in the
7 healthcare system to safeguard patients has been compromised, and the impact on public health has
8 been great.

9 **Therefore, Be It Resolved By the 2014 House of Delegates of the North Dakota Medical**
10 **Association** that the North Dakota Medical Association encourage safe injection techniques be
11 promoted and maintained in all hospitals, clinics, private practices, nursing homes, and other
12 medical care settings in North Dakota; and

13 **Be It Further Resolved** that the North Dakota Medical Association encourage healthcare
14 practitioner licensing boards to require safe injection practices training upon initial licensure and
15 annual thereafter by means of an approved program that meets the guidelines of the centers for
16 disease control; and that such training will be documented by each agency, institution, or office
17 where healthcare practitioners are employed.

Resolution No. 4

Introduced By: **Commission on Ethics**

Subject: **Disrespect and Derogatory Conduct in the Patient-Physician Relationship**

1 **Whereas**, the American Medical Association has affirmed principles regarding patient rights in E-
2 10.01 Fundamental Elements of the Patient-Physician Relationship; and

3 **Whereas**, the American Medical Association has affirmed principles regarding Physician and
4 patient conduct in Ethical Opinion 9.123, "Disrespect and Derogatory Conduct in the Patient-
5 Physician Relationship"; and

6 **Whereas**, the relationship between patients and physicians is based on trust and should serve to
7 promote patients' well-being while respecting their dignity and rights. Trust can be established and
8 maintained only when there is mutual respect; and

9 **Whereas**, physicians recognize the importance of patient autonomy, including a patient's right to
10 choose his or her physician. Physicians further recognize the importance of ensuring that each
11 patient has an identified physician responsible for the patient's care; and

12 **Whereas**, patients who use inappropriate language or actions toward physicians seriously undermine
13 the integrity of the patient-physician relationship and there needs to be appropriate institutional
14 mechanisms to address abusive behavior by patients, appropriate psychiatric referral or consultation
15 as a part of the treatment plan if the abusive conduct is a consequence of a mental disorder and an
16 appropriate mechanism to ensure continuity of care for a patient who persistently declines care from
17 the responsible health care provider.

18 **Therefore, Be It Resolved By the 2014 House of Delegates of the North Dakota Medical**
19 **Association** that the NDMA will encourage health care organizations to develop best practices for
20 attending to abusive patients and encourage development of guidelines for health care providers to
21 follow in non-life threatening situations when they encounter patients who verbally abuse or threaten
22 physical abuse.

Resolution No. 5

Introduced By: **NDMA Council**

Subject: **Behavioral Health**

1 **Whereas,** one in four adults (approximately 61.5 million Americans) experience a mental illness in a
2 given year; and one in 17 adults (about 13.6 million Americans) live with a serious mental illness
3 such as schizophrenia, major depression or bipolar disorder; and

4 **Whereas,** serious mental illness costs America $193.2 billion in lost earnings per year and mood
5 disorders such as depression are the third most common cause of hospitalization; and

6 **Whereas,** suicide is the tenth leading cause of death in the United States (more common than
7 homicide) and is the third leading cause of death for ages 15 to 24 years, resulting in approximately
8 100 deaths by suicide per day in the United States; and

9 **Whereas,** approximately 60 percent of adults received no mental health services in the previous
10 year; and

11 **Whereas,** the treatment of mental illness is effective in saving and improving lives and when there is
12 the opportunity to get proper treatment, then recovery to a productive life is possible.

13 **Therefore, Be It Resolved By the 2014 House of Delegates of the North Dakota Medical**
14 **Association** that NDMA advocate in the 2015 legislative session to significantly increase funding to
15 the ND Department of Human Services so as to increase and improve the delivery of mental health
16 services throughout our state.

Resolution No. 6

Introduced By: **Robert Beattie, MD**
NDMA Delegate to the American Medical Association

Subject: **Support of Iowa Medical Society Resolution to the AMA House of Delegates on Access and Equity in Telemedicine**

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

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

5 **Whereas,** the Iowa Medical Society Delegation will introduce a resolution on the subject of *Access*
6 *and Equity in Telemedicine Payments* at the American Medical Association House of Delegates
7 2014 Interim Meeting (Appendix A), urging the AMA to establish policy that there should be no
8 geographic adjustment in payments for telemedicine, and lobby Congress to require the Centers for
9 Medicare & Medicaid Services (CMS) to: 1) pay for telemedicine services for patients who have
10 problems accessing physician specialties that are in short supply in areas that are not federally
11 determined "shortage" areas, if that area can show a shortage of those physician specialists; and 2)
12 eliminate geographic adjustments for telemedicine payment to providers; and

13 **Whereas,** the Iowa Medical Society Delegation has requested the North Dakota Medical
14 Association support the resolution.

15 **Therefore, Be It Resolved By the 2014 House of Delegates of the North Dakota Medical**
16 **Association** that the North Dakota Medical Association support the introduction of the resolution
17 *Access and Equity in Telemedicine Payments* at the American Medical Association House of
18 Delegates 2014 Interim Meeting (Appendix A).

Appendix A

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution ___
(I-14)

Introduced by: Iowa Delegation

Subject: Access and Equity in Telemedicine Payments

Referred to:

---

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

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

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

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

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

15 Whereas, Cost of telemedicine equipment is no different from one geographic area to another; and

16 Whereas, Practice costs for telemedicine are primarily based on the provider's time; and

17 Whereas, Paying higher telemedicine rates to out-of-state physicians could exacerbate shortages of physicians
18 in states with lower payment rates; and

19 Whereas, Physician time and work should not be devalued geographically; therefore, be it

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

25

Resolution No. 7

Introduced By: **Robert Beattie, MD**
NDMA Delegate to the American Medical Association

Subject: **Support of Iowa Medical Society Resolution to the AMA House of Delegates on Price Transparency**

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

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

5 **Whereas**, the Iowa Medical Society Delegation will introduce a resolution on the subject of *Price*
6 *Transparency* at the American Medical Association House of Delegates 2014 Interim Meeting
7 (Appendix A), urging the AMA to: 1) develop an educational program by early 2015 for physicians
8 that would make healthcare price and reimbursement site differences clear; and 2) work with the
9 Center for Healthcare Transparency (CHT), the Health Care Cost Institute (HCCI), and the Centers
10 for Medicare & Medicaid Services (CMS) to make their websites easier to access and use, and make
11 their data for hospital and physician prices and payments more accurate and useful for physicians,
12 purchasers, and patients; and

13 **Whereas**, the Iowa Medical Society Delegation has requested the North Dakota Medical
14 Association support the resolution.

15 **Therefore, Be It Resolved By the 2014 House of Delegates of the North Dakota Medical**
16 **Association** that the North Dakota Medical Association support the introduction of the resolution
17 *Price Transparency* at the American Medical Association House of Delegates 2014 Interim Meeting
18 (Appendix A).

Appendix A

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution ___
(I-14)

Introduced by: Iowa Delegation

Subject: Price Transparency

Referred to:

---

1 Whereas, Physicians are being asked to be more cost-conscious by many different payers, including our
2 government; and

3 Whereas, Patients are increasingly facing more cost-sharing in health insurance products, including the
4 Affordable Care Act public exchange products; and

5 Whereas, Physicians are asked to help patients avoid financial harm by choosing their tests and treatments
6 wisely; healthcare prices, depending on site of care, can vary ten-fold or more; and

7 Whereas, There is a lack of transparency regarding healthcare prices and costs; and

8 Whereas, The Centers for Medicare & Medicaid Services (CMS) has published data on hospital and physician
9 payments but the figures are not complete or accurate, and websites are very difficult to navigate and find
10 usable data; and

11 Whereas, The Center for Healthcare Transparency (CHT) and Health Care Cost Institute (HCCI) will be
12 publishing transparent data on healthcare costs soon; and

13 Whereas, Physicians who might be making decisions on where they may choose to practice (such as hospital-
14 employment vs. independent practice) have had little information on the differences in reimbursement for
15 different sites of care; and

16 Whereas, Physicians in Accountable Care Organizations (ACOs) need to know the prices of many different
17 services and the differences in cost for sites of care; therefore, be it

18 RESOLVED, That our AMA will: 1) develop an educational program by early 2015 for physicians that would
19 make healthcare price and reimbursement site differences clear; and 2) work with the Center for Healthcare
20 Transparency (CHT), the Health Care Cost Institute (HCCI), and the Centers for Medicare & Medicaid
21 Services (CMS) to make their websites easier to access and use, and make their data for hospital and
22 physician prices and payments more accurate and useful for physicians, purchasers, and patients.

North Dakota Medical Association Constitution

ARTICLE I -- TITLE

The name of this organization shall be the North Dakota Medical Association.

ARTICLE II -- MISSION

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

ARTICLE III -- DISTRICT MEDICAL SOCIETIES

The Association is composed of those District Medical Societies which hold charters from this Association.

ARTICLE IV -- MEMBERS

The North Dakota Medical Association is composed of individual members of District Medical Societies and others as provided in the By-Laws.

ARTICLE V -- HOUSE OF DELEGATES

The legislative and policy-making body of the Association is the House of Delegates composed of elected representatives and others as provided in the By-Laws. The House of Delegates shall transact all business of the Association not otherwise specifically provided for in this Constitution and By-Laws and shall elect the general officers except as otherwise provided in the By-Laws.

ARTICLE VI -- COUNCIL

The Council shall be the executive body of the Association. It shall have charge of the property and financial affairs of the Association and shall perform such duties as are prescribed in the By-Laws.

ARTICLE VII -- GENERAL OFFICERS

The general officers of the Association shall be a President, Vice-President, Immediate Past President, Secretary-Treasurer, Speaker of the House of Delegates, and one or more Councillors from each District Medical Society. Their qualifications and term of office shall be provided in the By-Laws.

ARTICLE VIII -- CONVENTIONS

The House of Delegates shall meet annually and at such other times as provided in the By-Laws, in cities recommended by the Council and approved by the House of Delegates.

ARTICLE IX -- DUES AND ASSESSMENTS

The Council shall recommend to the House of Delegates the amount which the members should pay for dues and other assessments. The House of Delegates shall approve all dues and assessments.

ARTICLE X -- AMENDMENTS

The House of Delegates may amend any article of this Constitution by:

1) An affirmative vote of two-thirds of the delegates seated at a session of the House of Delegates, provided that such amendment shall have been presented at a prior meeting of the House of Delegates; or

2) An affirmative vote of two-thirds of the delegates seated at a session of the House of Delegates, provided that such amendment shall have first been approved by the Council, and submitted by the Chairman of the Council to the House of Delegates, and provided that the Chairman of the Council shall have caused to be furnished a copy of the amendment to each member of the Association at least 60 days prior to the beginning of the meeting.

Amended 5/3/97

North Dakota Medical Association By-Laws

CHAPTER I

MEMBERSHIP (QUALIFICATION AND RIGHTS)

SECTION 1. There shall be Active, Life, Alliance, and Allied Health Professional members of the Association.

SECTION 2. There shall be four categories of Active Members:

a. Licensed allopathic or osteopathic physicians who are members in good standing of a District Medical Society in this state and who have paid their dues and assessments.

b. Resident physicians in an approved North Dakota resident training program who are members in good standing of a District Medical Society in this state and who have paid their dues and assessments.

c. Physicians who are active duty members of a uniformed service for at least fifty percent of the dues period, who are members in good standing of a District Medical Society in this state and who have paid their dues and assessments.

d. Medical students who are enrolled at the University of North Dakota School of Medicine and Health Sciences and who submit a student membership application form.

Active members referred to in SECTION 2, subsection “a”, shall have all the rights of membership including the right to vote and be an officer of the Association.

Active members referred to in SECTION 2, subsection “b”, “c”, and “d” of this chapter shall have all the rights of membership, except the right to be an officer of the Association. Active members in these classes except those in SECTION 2, subsection “d”, shall have the right to be an officer of the Association if they pay the full dues and assessments of an Active member as described in SECTION 2, subsection “a”.

SECTION 3. Life Members. Upon retirement from active practice, any physician who is a member of the Association is eligible for Life membership following approval by the Council. Such members shall pay no dues and enjoy the same privileges as Active Members, including the right to vote, but may not be an officer in the Association.

SECTION 4. Alliance Members. A physician’s spouse who is a member in good standing of the NDMA Alliance is an Alliance Member of the Association. Alliance Members may not be elected to office.

SECTION 5. Allied Health Professional Members. Persons who belong to one of the following classes may become Allied Health Professional Members. Allied Health Professional Members shall not have the right to be elected to office.

1. Dentists who hold the degree of D.D.S. or D.M.D., who are members of the North Dakota Dental Association;

2. Pharmacists who are members of the North Dakota Pharmaceutical Association;

3. Teachers of medicine or of the sciences allied to medicine that are citizens of the United States and are not eligible for Active membership;

4. Advanced Registered Nurse Practitioners who are members of the North Dakota Nurses Association; and

5. Physician Assistants who are members of the North Dakota Academy of Physician Assistants.

The Council shall accept or reject each application for Allied Health Professional membership.

SECTION 6. No person who has been suspended or expelled from any District Medical Society of this Association, or whose name has been dropped from its roll of members shall be entitled to any of the rights or benefits of this Association, nor be permitted to take part in any of its proceedings until such time as that person has been reinstated as a member in good standing within a District Medical Society in this State.

CHAPTER II

ANNUAL AND INTERIM MEETINGS OF THE ASSOCIATION

SECTION 1. The Annual Meeting of the Association shall be held on the dates and at the location as set by the House of Delegates. The House of Delegates and the Council shall meet at the time and place of the Annual Meeting of the Association.

SECTION 2. Interim Meetings of the House of Delegates may be called by the President or the Council or on petition of one-third of the total number of delegates.

Notices of such Interim Meetings shall be delivered to all officers of the Association, to the President and Secretary of each District Medical Society, and to each delegate at least thirty days before the date of the Interim Meeting. All notices shall include information as to the purpose or purposes of the Interim Meeting, time, date, and location.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually.

SECTION 2. Each District Medical Society shall be entitled to send to the House of Delegates each year, one delegate for each fifteen members and one for each major fraction thereof based on the District Medical Society’s Active membership (not to include medical student members), Limited membership, and Life membership as of December 31 of the year preceding the Annual Meeting of the Association. A District Medical Society holding a charter from this Association with less than fifteen members shall be entitled to one delegate.

The Resident members of the Association shall be entitled to one Resident delegate.

The Medical Student members of the Association shall be entitled to one Medical Student delegate, to be selected by the American Medical Association Medical Student Section - University of North Dakota School of Medicine and Health Sciences.

Any AMA recognized Specialty Society which is organized within the state shall be entitled to one delegate, provided the Specialty Society has requested representation in the House of Delegates, and approval has been given by the House of Delegates.

In case a regularly elected delegate or alternate is not present at the Annual Meeting of the Association, the Speaker of the House of Delegates may appoint a member from the same Medical District Society to serve as a delegate and shall have the rights and privileges of the regular delegate.

The following shall have the privileges of the floor but, if not a delegate, do not have the right to vote: The President of the Association, the Vice-President, the Councillors, the Secretary-Treasurer, the Past Presidents, the Association Legal Counsel, the Executive Director, and the Delegate(s) and Alternate Delegate(s) to the American Medical Association.

Each delegate must be a member of the Association.

SECTION 3. The delegates present at a properly noticed meeting shall constitute a quorum for the transaction of business. All meetings of the House of Delegates shall be open to all members of the Association.

SECTION 4. The House of Delegates shall, upon application, provide and issue charters to District Medical Societies organized to conform to the spirit of this Constitution and By-Laws.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. All elections shall be by ballot and a majority of the votes cast shall be necessary for election. In the event more than two nominees are running for any individual office and no nominee receives a majority of votes on the first ballot, a subsequent ballot shall be conducted. The two nominees receiving the highest number of votes shall be placed on the final ballot. However, if there is only one nomination for an office, the election may be made by acclamation upon unanimous consent of the members of the House of Delegates present and voting without ballot.

SECTION 2. Nominations for the offices of President, Vice-President, Secretary-Treasurer, Speaker of the House of Delegates, and Delegate(s) and Alternate Delegate(s) to the American Medical Association shall be submitted by the District Medical Societies to the office of the Executive Director at least 60 days prior to the Annual Meeting. The President of the Association shall appoint a Nominating Committee whose duties include, but are not limited to (1) affirming the willingness of the nominees to serve; (2) obtaining nominations for offices in which nominations have not been submitted; and (3) informing the membership of the nominees prior to the Annual Meeting. The election of officers shall be held during the last session of the House of Delegates at the Annual Meeting.

SECTION 3. There may be additional nominations by members of the House of Delegates for offices in the Association. The Speaker shall call for such nominations during the first session of the House of Delegates.

SECTION 4. The President, Vice-President, Secretary-Treasurer, and Speaker of the House of Delegates shall be elected annually by the House of Delegates to serve for a term of one year. Officers may, but need not be, members of the House of Delegates. A member of the Association may serve two full consecutive one year terms as President, two full consecutive one year terms as Vice-President, and unlimited terms in all other offices under this section. The outgoing President shall automatically succeed to the office of Immediate Past President and may hold the office for two consecutive one-year terms. A President or Vice President who serves two

consecutive one-year terms may not be reelected to that office unless the office is held by another Active member for at least one term immediately preceding the reelection.

SECTION 5. The House of Delegates shall elect the Delegate(s) and the Alternate Delegate(s) to the American Medical Association. The term of this office shall be two years beginning January 1 after the election. An Active member so elected may serve three consecutive two-year terms as an alternate delegate and three consecutive two-year terms as a delegate. An Active member who serves three consecutive two-year terms as alternate delegate or delegate may not be reelected to that office unless the office is held by another Active member for at least one term immediately preceding the reelection.

SECTION 6. The District Medical Societies shall elect a Councillor(s) to represent their District Medical Society for a term of three years. A Councillor may serve an unlimited number of terms. The name of the District Medical Society Councillor(s) shall be submitted by the District Medical Society to the office of the Executive Director within ten days of the election.

SECTION 7. Any officer or Councillor, or any Association Delegate or Alternate Delegate to the American Medical Association, may resign from their elected office, or may be removed by a majority vote of the House of Delegates.

CHAPTER V

DUTIES OF OFFICERS

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

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

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

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

SECTION 5. Executive Director. The Council shall employ, and determine the compensation of an Executive Director. The Executive Director shall provide, at the Association's expense, a bond in an amount determined by the Council. The Council shall approve a job description for the Executive Director.

The Executive Director shall give a report of the staff activities at the Annual Meeting of the Association, or as requested by the President or the chairman of the Council.

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

CHAPTER VI

THE COUNCIL

SECTION 1. The Council is the executive body of the Association and is responsible for implementing the policy decisions of the House of Delegates, the supervision of the staff, and the finances of the Association. The Council has the full authority and power of the House of Delegates between meetings of the House of Delegates. The chairman of the Council shall report to the House of Delegates at each meeting of the House of Delegates.

SECTION 2. The members of the Council are the President, the Vice-President, the Secretary-Treasurer, the Immediate Past President as Councillor at Large, the Speaker of the House, the Speaker of the House, the AMA Delegate and the AMA alternated Delegate, the Commission Chairs, and the Councillors. The Councillors shall be apportioned in the following manner. District Medical Societies with 1-99 Active members shall be represented by one Councillor. District Medical Societies with 100-249 Active members shall be represented by two Councillors. District Medical Societies with 250 or more Active members shall be represented by three Councillors. For the purpose of this section, Active members shall be those referred to in Chapter 1, SECTION 2, Subsection "a".

SECTION 3. The Council shall meet during the Annual Meeting of the Association and at the call of the Chairman, the President, or three Councillors who may not be from the same Medical Society District.

SECTION 4. If a Councillor fails to attend three consecutive meetings of the Council without advance excuse or fails to perform the duties expected of a Councillor, the Council may declare the position vacant. The District Medical Society shall promptly elect another Councillor to complete the remainder of the term.

SECTION 5. The Council shall recommend to the House of Delegates the annual dues and assessments for each category of members.

SECTION 6. The Council shall approve an annual budget for the operations of the Association. No person shall obligate Association funds unless the expenditure is included in the budget.

SECTION 7. The Council members present at a properly notice meeting is a quorum for the transaction of business.

SECTION 8. Each District Medical Society shall report to the House of Delegates at the Annual Meeting by way of their Councillor(s).

SECTION 9. The executive committee of the Council is comprised of the President, Vice President, Secretary-Treasurer, Immediate Past President, and Speaker of the House. The executive committee shall manage the business of the Association as necessary between meetings of the Council and report to the Council, and perform other functions as assigned by the Council.

CHAPTER VII

COMMISSIONS

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

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

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

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

Commission on Socio-Economics to address medical economics;

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

SECTION 2. The President shall appoint the chairman, the members, and at least one Councillor who will be the liaison to the Council. The members shall include at least one Resident and four medical students, one from each class at the University of North Dakota School of Medicine and Health Sciences. The medical students must be members of the Association and must be recommended by the American Medical Association Medical Student Section □ University of North Dakota School of Medicine and Health Sciences.

SECTION 3. Each Commission shall meet at least once annually.

SECTION 4. The President may also establish additional task forces and ad hoc committees.

CHAPTER VIII

ASSESSMENTS

SECTION 1. The House of Delegates shall fix the dues and assessments for each membership category.

SECTION 2. Any member who fails to pay the annual dues or assessments on or before March 1 shall not be permitted to participate in any of the business or proceedings of the Association or the House of Delegates until the dues and assessments have been paid.

SECTION 3. The Executive Director may prorate the dues and assessments for a new member who joins the Association after April 1.

SECTION 4. The chairman of the Council may waive part or all of the annual dues and assessments for a member if payment of the dues or assessments would be a financial hardship.

CHAPTER IX

RULES OF CONDUCT

The principles set forth in the Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

CHAPTER X

DISTRICT MEDICAL SOCIETIES

SECTION 1. There shall be established the following numbered District Medical Societies:

1. First District Medical Society includes the counties of Cass, Richland, Ransom and Sargent.

2. Second District Medical Society includes the counties of Bottineau, Rolette, Towner, Pierce, Benson, Ramsey, Eddy, Foster, Wells and the western part of Nelson.

3. Third District Medical Society includes the counties of Walsh, Grand Forks, Cavalier, Pembina and the eastern part of Nelson.

4. Fourth District Medical Society includes the counties of Burke, Mountrail, the northern part of McLean, Renville, Ward and McHenry.

5. Fifth District Medical Society includes the counties of Barnes, Dickey and LaMoure.

6. Sixth District Medical Society includes the counties of Mercer, Oliver, the southern part of McLean, Sheridan, Morton, Burleigh, Kidder, Grant, Sioux, Emmons, Logan, and McIntosh.

7. Seventh District Medical Society includes the county of Stutsman.

8. Eighth District Medical Society includes the counties of Divide, Williams, and McKenzie.

9. Ninth District Medical Society includes the counties of Dunn, Stark, Billings, and Golden Valley.

10. Tenth District Medical Society includes the counties of Traill, Griggs and Steele.

11. Eleventh District Medical Society includes the counties of Slope, Hettinger, Bowman, and Adams.

SECTION 2. Charters to District Medical Societies shall be issued only by the House of Delegates, and shall be signed by the President and the Secretary-Treasurer of this Association. The House of Delegates shall have authority to revoke the charter of any District Medical Society whose actions are in conflict with the letter or spirit of the Constitution and By-Laws, or if the District Medical Society has ceased functioning or participating in activities of the Association.

SECTION 3. Each District Medical Society shall judge the qualifications of its own members.

SECTION 4. When a member in good standing in a District Medical Society moves to another District Medical Society in this state, the member's name, upon request, shall be transferred, without cost, to the roster of the other District Medical Society.

SECTION 5. A physician may hold membership in the District Medical Society most convenient to attend, provided no objection is made by the District Medical Society, in which the member resides.

SECTION 6. Election of Delegate(s) and Alternate Delegate(s) - As provided in accordance with CHAPTER III, SECTION 2, Paragraph 1.

SECTION 7. Nomination of Association Officers - As provided in accordance with CHAPTER IV, SECTION 2.

SECTION 8. Election of Councillors - As provided in accordance with CHAPTER IV, SECTION 6.

SECTION 9. Council Representation - As provided in accordance with CHAPTER VI, SECTION 2.

SECTION 10. The names of the District Medical Society Officers, Councillor(s), Delegate(s) and Alternate Delegate(s) shall be submitted by the District Medical Society to the office of the Executive Director within ten days of the election.

CHAPTER XI

AMENDMENTS

These By-Laws may be amended by the House of Delegates:

1. At any Annual Meeting, in the same manner as prescribed by Article X of the Constitution, or

2. By an affirmative vote of two-thirds of the delegates seated at the Annual Meeting provided the amendment is introduced at the first regularly scheduled session, and then laid over to a succeeding session before final action is taken, or

3. By the unanimous consent, for introduction and final passage, of the seated delegates at the last regularly scheduled session of the Annual Meeting, or

4. By an affirmative vote of two-thirds of the delegates seated at a special meeting called for the purpose of amending the By-Laws provided that each delegate and alternate shall have been furnished a copy of the proposed amendments at least thirty days prior to the beginning of the special meeting.

CHAPTER XII

REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES

SECTION 1. Appointment.

The Speaker may appoint from the House any ad hoc reference committee and shall designate the committee chairman. These Committees shall serve only during the Annual Meeting at which they were appointed.

CHAPTER XIII

MISCELLANEOUS

SECTION 1. The fiscal year of this Association shall be the calendar year.

SECTION 2. Meetings of the House of Delegates, the Council, and any Association commissions or committees shall be governed by the most current version of "Robert's Rules of Order," unless a majority of the entity adopts different parliamentary rules.

Amended 5/3/97, 5/9/98, 09/18/99, 09/23/00, 9/22/01, 09/28/02, 10/1/04, 9/19/08, 09/23/11