



Physician

December 2013

NDMA Annual
Meeting Recap

Mandatory Reporting
of Abuse

DocbookMD

Opioid Prescribing

Trauma Update

*The Golden Years of
Medicine are Ahead of Us*



In this Issue

North Dakota Medical Association

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Katie Cashman, Editor

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Physician Advocate

The Golden Years of Medicine are Ahead of Us

This is my first opportunity to write the *Physician Advocate* column as President of the North Dakota Medical Association. You elected me at the Annual Meeting of NDMA on October 3, 2013, in Fargo. This is a very un-North Dakotan thing to say, but I do want to be President of the NDMA. I take on the position with excitement and trepidation but ultimately, I feel comfortable that the people involved in the NDMA will continue to keep the organization working productively and wisely.

It has become a tradition for the President of NDMA to have a theme for his or her term; my theme is *The Golden Years of Medicine are Ahead of Us*.

How often have we heard an 'old timer' tell us of an event that ruined medicine? I came home to North Dakota to establish my practice in 1983 (that qualifies me as an old timer). Let's be realistic- who wants to go back to those days, or any of the old days, to practice medicine? Think of some of the changes in the last 3 decades:

- The promise that everyone who needs health care will have access
- Imaging that defines anatomy and pathology so we can 'see what we are doing'
- Diagnostic tests that define function and abnormalities of that function
- Focused pharmacology to address abnormalities and minimize complications
- Surgical techniques that have improved our results and minimized morbidity
- Initiatives to improve patient safety and minimize medical mistakes
- Mapping of the human genome

Personally, I look forward to the individual genome being part of our medical record and factoring into

diagnostic and therapeutic decisions. This list may bring to mind other advances you are thankful for; it's easy to imagine that our combined lists may never end.

The idea of the 'Golden Years of Medicine' being ahead of us is a very pragmatic one as well. If that is to be true, it is our responsibility; yours, mine, and organized medicine's, to make it so.

Think of our day, every day. Every moment at work, every decision, every action taken on behalf of our patients is monitored, regulated, administered, and judged by a variety of legislative bodies, regulators, boards, and businesses. The interests of physicians and our patients must be represented in all of the conversations regarding health care. This is most effectively done through a unified body of physicians. The North Dakota Medical Association will continue to serve as the voice of that unified body; to look out for our patients' interests and our ability to provide patient care.

I do not have any sweeping programmatic changes for the NDMA. We need to continue doing what we do: look after the care and welfare of our patients, the people of North Dakota. I have always believed that the value of the NDMA is in

Health care policy does not come to be in North Dakota without NDMA's participation.

relationships. NDMA has collegial and constructive relationships with the organizations, agencies, commissions,



Steven P. Strinden, MD

and stakeholders who make health care policy and we participate in virtually all policy conversations regarding health care. Health care policy does not come to be in North Dakota without NDMA's participation.

So, as an organization, NDMA will do the work we are to do. What are you to do? Easy, be a good representative of North Dakota medicine through one or more of these avenues:

- Look after the interests of your patients
- Participate in your hospital's medical staff functions
- Attend your District Medical Society meetings
- Serve as an officer or councillor
- Serve on an NDMA Commission
- Attend the next NDMA annual meeting and help us formulate our policy
- Be a member of the AMA and support the people working on our interests on the national level
- Be a member of your specialty and subspecialty organizations
- Make a contribution to NDMA PAC and AMPAC
- Or better, contribute directly to people running for office in your community
- Better yet, do some work on a friend's or neighbor's campaign
- Run for an office in your community

If the 'Golden Years of Medicine' are ahead of us, they will be because we made them so. §

Advocacy Efforts on the Federal and State Levels

Though we are not in the throes of a state legislative assembly, NDMA's advocacy efforts are in full force during this interim period. As you know, this is a particularly critical time for medicine on federal and state levels. Issues such as Medicare, health care reform implementation, a state review of the behavioral health system, and Worker's Compensation are on the forefront.

SGR UPDATE

In July, the US House Ways and Means Committee unanimously passed a draft of legislation that would repeal the Sustainable Growth Rate (SGR). In the meantime, other issues have risen to the top of congressional politics, including the government shutdown, the debt ceiling, and the implementation of the Health Insurance Marketplace. Despite these pressing issues, Congress is taking another run at the SGR repeal. On October 30, the US Senate Finance Committee and US House Ways and Means Committee released a draft legislative framework that would repeal the SGR formula, building on the

work of the US House Energy and Commerce Committee.

Organized medicine is guardedly optimistic about this possible accomplishment in Medicare payment reform. It has been working toward the repeal of the SGR, a program with problems since its inception, for many years and now, with the strength of bipartisan support, the repeal could be a reality. However, the plan proposed is not without some hurdles, such as:

- A ten year freeze of the annual fee schedule payment updates; annual positive updates would begin in 2024
- A new "Value-Based Performance (VBP) payment program" would be used to adjust payments beginning in 2017. This new VBP program essentially combines all the current incentive and penalty programs (e.g., value-based modifier, meaningful use, PQRS) into one budget-neutral program. Payments could be increased or decreased significantly, depending on how well a physician scores relative to others on a composite performance score
- Physicians participating in certain Alternative Payment Models (APMs), including the patient-centered medical home, would be exempt from the VBP program. Revenue thresholds are established for APMs other than the medical home model, and two-sided risk and a quality component would be required to qualify for a 5% bonus in 2016-2021
- Health and Human Services (HHS) would publish utilization and payment data for physicians on the Physician Compare web site (medicare.gov/physiciancompare)

Organized medicine is guardedly optimistic about this possible accomplishment in Medicare payment reform. It has been working toward the repeal of the SGR, a program with problems since its inception, for many years and now, and with the strength of bipartisan support, the repeal could be a reality.



Courtney M. Koebele, JD

A permanent repeal of the SGR is critical to the goal of ensuring security, stability, and access for seniors and to provide the essential foundation for the development of new payment models and delivery reforms.

Unfortunately, many of the details are yet to be seen, including a way to pay for the new system. Many of the terms are required to be "budget neutral" in that certain payments are reduced to pay for updates. Of particular importance to North Dakota physicians is the geographic disparity that is a core component in Medicare reimbursement (and what the Frontier Amendment corrected). From our view, this is a matter of fundamental fairness – whatever headway we can make on the issue will benefit patients in North Dakota over the long haul. A permanent repeal of the SGR is critical to the goal of ensuring security, stability, and access for seniors and to provide the essential foundation for the development of new payment models and delivery reforms. The SGR must be replaced this year with a system that keeps pace with the cost of running a practice and is backed

by a fair and stable funding formula. We oppose further temporary patches to the payment formula that serve to increase both the severity of future cuts and the cost of a permanent solution.

NORTH DAKOTA LEGISLATIVE INTERIM MEETINGS

There are a total of 25 interim legislative committees that meet throughout the two years between state legislative sessions. At the conclusion of the interim period, several committees produce bill drafts which will be introduced, debated, and voted on during the 2015 session. Therefore, because legislation is actively developing, it is vitally important that NDMA be present during these hearings to present information and offer input.

Health Care Reform Committee

Based on legislation passed in 2013, the committee is tasked with the following:

- Tracking the implementation of the ACA
- Considering health care delivery system alternatives to the ACA, including consideration of the feasibility and desirability of applying for a state innovation waiver
- Considering health care delivery system actions that may complement or work within the requirements of the ACA

The Issue of State Innovation Waivers

Section 1332 of the ACA authorizes states to submit applications for state innovation waivers. The final rules for these waivers were published March 14, 2011, providing that beginning in 2017, a state may qualify for a state innovation waiver to allow the state to pursue its own innovative strategies to ensure residents have access to high quality, affordable health insurance. In order to qualify for a waiver, the state's plan must provide affordable insurance coverage to at least as many residents as the ACA and may not increase the federal deficit. The

committee continues to meet and gather background information to explore this issue further.

Workers Compensation Review Committee

At the most recent Worker's Compensation review committee meeting, the Office of the State Auditor reported that the following four elements will be included in the independent WSI performance evaluations:

- Independent Medical Evaluations (IMEs) including: a review and documentation of the entire IME process and a determination of the frequency the IMEs were conducted by North Dakota physicians
- Fraud investigations, including a review and documentation of the processes WSI uses to detect and investigate employer fraud, employee fraud, and medical provider fraud
- Claims, including evaluating the appeals process available to claimants; sampling denied claims submitted to the DRO
- 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

The Workers Compensation committee members unanimously picked the

prevalence if it exists within North Dakota. ***The evaluation will make recommendations regarding legislative controls if any are needed.***

- Evaluate whether providing coverage for post-traumatic stress disorder resulting from workplace injury is an appropriate and feasible option

Human Services Committee

In its first meeting, the committee approved a request for funding from Legislative Management to hire a consultant to assist with the committee's study of behavioral health needs of youth and adults and to amend the proposed study plan relating to the study of behavioral health needs of youth and adults. They anticipate this will provide the committee with information regarding mental health parity, unmet mental health needs, and outcome data for behavioral health services provided with state funds. The Chairman of Legislative Management has authorized the committee to spend up to \$45,000 for the consulting services.

The consultant, which will be hired in January 2014, will develop a plan based on specific goals and objectives to improve behavioral health services in North Dakota and provide recommendations to implement the plan to improve behavioral health services in North Dakota.

It is important that physicians stay engaged in this public debate and play a role, which can be simpler than it sounds.

following additional items for the independent audit evaluation:

- Preferred Provider Program Study
- Evaluate the basis for determining annual cost of living adjustments for benefits
- Evaluation of North Dakota's Usage Rates Trends and Controls of Narcotic Utilization in comparison to similar states when adjusted for our labor force. Explore methodologies or systems that could be employed to address

Recommendations will identify the entity responsible for implementing the recommendation and necessary legislative changes.

Other studies assigned to this committee:

- Study the need for a comprehensive system of care for individuals with brain injury
- Study home and community-based services in the state

Continued on next page...

For the golden age of medicine to continue, NDMA needs your help to encourage your peers to join NDMA and to encourage our existing members to become more involved in Association activities, at both the district and state level. The more voices we have around the table, the stronger we are!

Health Services Committee

This committee was assigned several studies including:

- Funding provided by the state for autopsies
- Study how to improve access to dental services and ways to address dental service provider shortages
- Study the comprehensive statewide tobacco prevention and control plan
- Study the feasibility and desirability of community paramedics providing additional clinical and public health services

To see the work of all committees, go to legis.nd.gov/assembly/63-2013/session-interim and click on the committee which you are interested for more information.

It is important that physicians stay engaged in this public debate and play a role, which can be simpler than it sounds. You can contact our state's Congressional Delegation regarding the various federal issues, build a relationship with a state legislator to help ensure that appropriate medical care is provided for Medicaid patients, or get involved with your NDMA district to discuss these issues with your colleagues.

For the golden age of medicine to continue, NDMA needs your help to encourage your peers to join NDMA and to encourage our existing members to become more involved in Association activities, at both the district and state level. The more voices we have around the table, the stronger we are!§



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AMA Interim Meeting: November 2013

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/house-delegates/meeting-archives/2013-interim-meeting.page §



Pictured left to right: Shari Orser, MD; Steven Strinden, MD; Deb Geier, MD; Rob Beattie, MD; and Courtney Koebele, JD

Work in Progress

News from the Dean of the UND SMHS

In my last column, I discussed your School's Big Agenda for the academic year that started July 1, 2013: construction of the new building; class size expansion and enhanced retention efforts so graduates practice in North Dakota; consolidation of four basic science departments into one; and preparations for our Liaison Committee on Medical Education (LCME) reaccreditation visit that is scheduled for March 9–12, 2014. We are making good progress on all fronts, although attacking all four projects simultaneously certainly is straining the human resources of our small (but growing) school!

Nevertheless, most projects are coming along nicely. The schematic design phase for the building project has just been completed and the layout of the building now has been determined. A central corridor will literally, as well as figuratively, connect the building to the campus on one end and the

But class expansion doesn't result in more practitioners unless there also is an expansion in residency slots; fortunately, we've already been able to add nine slots each year, and we now have approval for eight more each year.

community on the other. And the School's community is all of North Dakota! Most of the classrooms and educational space for students will be along this central avenue, along with eight "Learning Communities" where students will learn, study, and prepare in an interprofessional environment. The central corridor will also house resources for the community, including meeting space and a learning hall. And like the Gorecki Alumni Center, people entering the building will find folks from our Alumni and Community Relations office along with staff from the Office of Student Affairs and Admissions. That way, community people, alumni, students, and prospective students will be greeted and welcomed immediately upon entering the facility. Pilings for the foundation should be going in during February, followed by the ground breaking in July 2014. The building is scheduled to open its doors on July 15, 2016, just in time for the entering Class of 2020.

Class size expansion is proceeding nicely. Our medical school class already has expanded from 62 to 70 students, and we'll expand again up to 78 students this summer with the arrival of the Class of 2018. But class expansion doesn't result in more practitioners unless there also is an expansion in residency slots; fortunately, we've already been able to add nine slots each year, and we now have approval for eight more each year. Ten applications from institutions around the state have been received for those slots, and the final decision on which residencies will be approved will be forthcoming soon. Unfortunately, we won't be able to fund all of the requests, because there are about double the number of requested slots as we have available.

Retention efforts appear to be paying off. Senior Associate Dean for Academic and Faculty Affairs Dr. Gwen Halaas



Joshua Wynne, MD, MBA, MPH

Our RuralMed scholarship program, where medical students who commit to practicing family medicine in a rural area of North Dakota for five years receive full medical school tuition relief, now has 19 students enrolled. That means 19 more family medicine physicians for rural North Dakota than we would have had otherwise.

and I recently traveled to Hettinger to meet with the medical staff and administration at West River Health Services. West River is welcoming four new physicians; all received their training through UND. And our RuralMed scholarship program, where medical students who commit to practicing family medicine in a rural area of North Dakota for five years receive full medical school tuition relief, now has 19 students enrolled. That means 19 more family medicine physicians for rural North Dakota than we would have had otherwise.

Dr. Malak Kotb is the founding chair of our consolidated Department of Basic Sciences. She has been onboard since late August, and the reorganization of our research enterprise along disease-focused lines (rather than the prior model that focused on disciplines) is progressing. Any big change like this always has some growing pains, but progress is being made. And despite a very tight and competitive environment for federal funding, the School had its most successful year ever in 2012–2013, with over \$27 million in research funding. That doesn't even include the recently announced major grant in epigenetics for \$10.5 million!

Finally, we are putting the finishing touches on our packet of information that we need to submit to the LCME in advance of the March 2014 visit. Preparation for the visit has been ongoing for about two years, and all of

I think that the North Dakota Legislature got it right when they stated that the primary purpose of the School is “...to educate physicians and other health professionals and to enhance the quality of life in North Dakota.”

the pieces in the submission finally are coming together. An enormous amount of data has to be submitted; the entire stack of printed information probably is about six inches thick! We will learn the composition of the survey team shortly, and Dr. Ken Ruit, who is the lead in our LCME preparation, will soon be coordinating with the team secretary to arrange the specifics of the visit.

All four of these big projects, along with everything else that we do at the SMHS, ultimately are focused on improving the

health and well-being of the people of North Dakota. I think that the North Dakota Legislature got it right when they stated that the primary purpose of the School is “...to educate physicians and other health professionals and to enhance the quality of life in North Dakota.” All of us at the School try to live up to that statement every day. And we rely on many of you to help train our students in the healing arts. We literally couldn't do it without you. Thank you, from all of the people in North Dakota! §



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Prescription Drug Abuse in North Dakota

Prescription drug abuse is a growing problem. According to the 2011 North Dakota Youth Risk Behavior Survey, 16% of high school students reported to have taken a non-prescribed prescription drug in their lifetime (YRBS, 2011). Also, almost 1 in 10 (9%) students attending a University System institution in the state have reported non-medical use of prescription drugs (CORE, 2012).

The misuse of prescription drugs impacts our families, friends and communities. Calls to the Hennepin Region Poison Center related to North Dakota prescription drug abuse has increased 102% from 2005 (113 calls) to 2012 (228 calls). Adults in treatment at North Dakota's Human Service Centers reporting prescription drugs, namely Codeine, Methylphenidate, Morphine Sulfate, Non-prescription Methadone, and Other Opioid Pain Relievers, as a primary, secondary, or tertiary substance increased from 12% in 2010 to 14% in 2011 ("2012 Comprehensive Status & Trends Report," ND Office of Attorney General).

In 2011, there were over 29 million pills dispensed in the state; this is 43 pills for every man, woman, and child in North Dakota.

But why is this a problem? What can be done about it? We know that in 2011, there were over 29 million pills dispensed in the state; this is 43 pills for every man, woman, and child in North Dakota (North Dakota Board of Pharmacy, 2011). Data also tells us that 71% of people who abuse prescription pain relievers obtain them from a friend or relative (NSDUH National Findings, 2010); therefore, the target for reducing prescription drug abuse has to be reducing access to prescription drugs. Decreasing access will decrease prescription drug abuse and related consequences.

North Dakota has taken several steps over the past few years to reduce prescription drug abuse in the state. In January 2012, the ND Indian Affairs Commission partnered with the North Dakota Department of Human Services Tribal Community Substance Abuse Prevention Program to launch a prescription drug prevention effort, "There's a New Dealer on the Rez" on North Dakota tribal areas. The goals of the effort were to encourage community members to lock medications and to provide information on appropriate disposal methods of unused medication. The message was communicated through print material (posters and rack cards), and both radio and video PSAs. Campaign material can be found here: nd.gov/dhs/prevention/tribal.

In July of 2012, North Dakota Department of Human Services launched a statewide, prescription drug campaign entitled, "Prescription Drug Abuse is a Growing Problem...You lock these, why not these?" The goal of this campaign was to raise awareness that prescription medication can be dangerous if abused and ask citizens to safeguard medications by keeping them locked up and to safely dispose of those medications no longer needed. Campaign material also promoted the *Take Back Program* in partnership with the Office of the Attorney General. This message was communicated through billboards, a community toolkit, state and local events, and print material (posters, rack cards, postcards). The ND Targeted Communities Program distributed campaign efforts locally.

The statewide campaign was supplemented with efforts in partnership with the North Dakota Pharmacy Board and the North Dakota Association of Realtors®. Packets that included posters and prescription bag insert reminding those picking up prescriptions to lock and safeguard their medications were distributed to pharmacies across the



Pam Sagness, LAC, Prevention Administrator with the Division of Mental Health and Substance Abuse Services

state in July of 2012. Presentations were conducted at Realtor® board meetings throughout the state educating realtors on the prescription drug abuse problem and providing them with a checklist for



homeowners on how to secure (including locking up prescription medication) their homes in preparation for open houses.

Campaign material can be found here: nd.gov/dhs/prevention/rxdrug.

Other efforts in the state include the *Prescription Drug Take Back Program* managed by the Office of the Attorney General and the Prescription Drug



Monitoring Program (PDMP). In

2009, the Office of The Attorney General launched the *Prescription Drug Take Back Program*. The Program provides North Dakota citizens with a safe and simple method to dispose of unused and unwanted over-the-counter and prescription medicines, thereby helping to protect our state's environment and keeping these drugs off the streets. Unused and unwanted medicines and prescription drugs (including controlled

Taskforce at Work to Reduce Abuse of Pharmaceutical Narcotics

Katie Cashman, NDMA

The Reducing Pharmaceutical Narcotics Taskforce, made up of representatives from the Attorney General's office, Bureau of Indian Affairs, Bureau of Criminal Investigation (BCI), city, county, and state law enforcement, Department of Public Instruction, Drug Enforcement Administration, North Dakota Board of Medical Examiners, North Dakota Board of Pharmacy, North Dakota Hospital Association, North Dakota Department of Human Services, North Dakota Medical Association, North Dakota Pharmacy Association, North Dakota State Legislature Representatives and Senators, Sanford Health (physicians and staff), United States Attorney's Office, and United States Congress, meets on a monthly basis to determine a prescription drug control strategy. The goal of this group is to implement a multi-pronged control strategy for the public and draft meaningful and enforceable legislation for the 2015 Legislative Assembly. Along the way, the group aims to attain solid buy-in from all parties represented and learn from what other states have accomplished.

Meeting since June 2013, the taskforce decided to structure goals based upon the four pillars of Preventing Prescription Drug Abuse, as determined by the 2013 National Drug Control Strategy: education; monitoring; disposal; and enforcement.

The goal of this group is to implement a multi-pronged control strategy for the public and draft meaningful and enforceable legislation for the 2015 Legislative Assembly.

Education plans involve advertising campaigns, integrating teachers on all levels - kindergarten through higher education, and increasing awareness amongst physicians, hospital care teams, and patients regarding all sides of the issue. BCI has started creating presentations for hospital staff audiences to let doctors, NPs, RNs, and other hospital staffers know about the rates of abuse in the community and the importance of keeping good records, in order to watch for abuse amongst hospital staff.

Of note in regards to the monitoring portion of the four-pillar strategy, the North Dakota Board of Pharmacy has secured a grant that will expedite connecting the Prescription Drug Monitoring Program (PDMP) to EPIC, in real time. The lack of connection of the PDMP to electronic health records is a notable concern for

Continued on page 15

substances) can be disposed of safely by depositing them in the secure disposal container, located in the lobby of the police department in the participating cities. For a listing of all the local *Take Back Programs*, visit the website at ag.nd.gov/PDrugs/TakeBackProgram.htm. As of October 2013, 5,699 lbs. of unwanted and unused medications has been collected and destroyed through the Attorney General's Take Back Program (ag.nd.gov/BCI/PrescriptionDrugAbuse.htm).

As of October 2013, 5,699 lbs. of unwanted and unused medications has been collected and destroyed through the Attorney General's Take Back Program.

Prescription Drug Monitoring Programs (PDMPs) track controlled substances prescribed by authorized practitioners and dispensed to pharmacies. North Dakota's PDMP was established in 2005 and became operational in 2008. The program, overseen by the Board of Pharmacy, collects data on all Schedule II, III, IV, and V controlled substances, including Tramadol and Carisoprodol, dispensed in North Dakota for patients residing in the state. Data are collected daily from pharmacies and dispensing practitioners. (Source: ND Board of Pharmacy)

Everyone can to be involved in this effort. Lock up and monitor your medications. Here are some tips:

- **Consider using a lock box or hide medications** in a discrete location in your home so they are not easy for others to find
- **Keep track of your medicine.** Count how many pills you have at any given time to check for missing pills
- **Don't share your medications under any circumstances.** If a family member or friend is injured, instead of "sharing" a pain reliever, make sure he or she sees a healthcare professional for care
- **Keep a low profile. Your medicines are your business.** There's no reason to tell people about the medicines you take
- **Properly dispose of old or unused medicines.** If a *Take Back Program* is not available, prescription drugs can be placed in a non-see-through container mixed with coffee grounds or kitty litter and thrown in the garbage
- **Store your medications in a secure and dry place** (not bathrooms) §

Corresponding Responsibility of the DEA and Updates to the Prescription Drug Monitoring Program (PDMP)

The Trickle-down effects from recent actions against Walgreens

In June of 2013, the DEA entered into an 80 million dollar settlement with Walgreens, the nation's largest pharmacy chain. Although the basis of the actions was not released, it seems to be evident that there were recordkeeping and dispensing issues that were not consistent with the expectations of the DEA. This serious action has created many ripples across the pharmacy community to more closely examine the meaning of the "Corresponding Relationship" between a practitioner and a pharmacist in the handling of controlled substance prescriptions.

As background, 21 C.F.R. § 1306.04 provides that while "the responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, a corresponding responsibility rests with the pharmacist who fills the prescription." The regulation further states, "the person knowingly filling such a purported prescription, as well as the person issuing it [is] subject to the penalties provided for violations of the provisions of law relating to controlled substances." Thus, a pharmacist is prohibited from filling a prescription for controlled substances when he/she either knows or has reason to know that the prescription was not written for a legitimate purpose. Further, when prescriptions



Mark Hardy, Pharm D, Assistant Executive Director, ND Board of Pharmacy

are not issued for a legitimate medical purpose, a pharmacist may not intentionally close his/her eyes and thereby avoid actual knowledge of the real purpose of the prescription.

In response to the DEA's action, it appears Walgreens has implemented new processes to ensure each prescription is valid and has a legitimate medical purpose. This has caused much animosity in the provider community as often this involves the pharmacist circling back to the practitioner to ensure its legitimacy. The DEA's action has not only created concern but also awareness by our pharmacists in North Dakota of their responsibilities and the implications of not being diligent in their dispensing habits.

Although North Dakota does not have any Walgreens located in the state, you may notice in your practice that you are receiving more communications from your local pharmacists to ensure

Signup for Direct Access to the ND Prescription Drug Monitoring Program (PDMP) is Easy and Simple

To obtain an online direct access account to access PDMP reports on your patients, follow these steps:

1. Go to <http://www.nodakpharmacy.com/directaccess.asp>
2. You will click on the "Practitioner, Pharmacist, and Delegate Access Request Form" as seen below. Enter the username and password
3. Once you have completed the online form you will be able to print it and sign it in the presence of a notary (a registered notary is available in most healthcare facilities and banks)
4. Mail the signed form to our office and we will contact you to provide your username and password to run patient queries

To receive access to the Prescription Drug Monitoring Program:

1. Fill out the Applications & Agreements

(most of the fields are fillable online)

[Practitioner, Pharmacist, and Delegate Access Request Form](#)

When prompted,

username: **newacct**

and password: **welcome**

2. Print, Notarize, Sign, and Mail the Forms to:
ND Board of Pharmacy, PDMP
1906 E. Broadway Ave.
Bismarck, ND 58501

legitimacy before dispensing a prescription. As prescription drug abuse is such a widespread concern, it is important that we work as an interdisciplinary team to inhibit abuse and enhance patient care. We hope that you understand the implications for pharmacists which are now highlighted further by the DEA in addressing controlled substance prescriptions. Please continue to work with our pharmacists to provide proper care.

As prescription drug abuse is such a widespread concern, it is important that we work as an interdisciplinary team to inhibit abuse and enhance patient care.

Board of Pharmacy receives grant to incorporate PDMP into Electronic Health Records

The Board of Pharmacy recently received a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to incorporate PDMP information into various electronic health records. The primary project will be to integrate the PDMP within the North Dakota Health Information Network (NDHIN). This will allow practitioners to view a patient's PDMP report directly from the NDHIN. This is something that we have long desired to have available to the medical community. We feel this should improve your workflow in allowing easier and more convenient access to the PDMP. The initial technical discussions are currently happening and our hope is to have this functional in early 2014. ☺

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TASKFORCE AT WORK...

Continued from page 13

everyone on the taskforce; the Board of Pharmacy wants to ensure that utilization of the PDMP is seamless and easily accessible to all prescribers.

The law enforcement groups and the pharmacy professionals primarily handle the disposal aspect through take-back events, mail-in options, and collection receptacles. That being said, the group is looking into other avenues that could aid in the disposal of these dangerous narcotics.

For enforcement changes or improvements, the group as a whole is looking at this to be viewed less as criminal behavior but more as a mental health, physical health, and/or an addiction issue with the individual. Appropriate training and accessible resources will be crucial to make enforcement meaningful, intentional, and helpful.

The state legislators that are involved with this taskforce want physicians to be more active in their PDMP usage. The legislators wish to draft legislation that would require mandatory participation of all physicians with the PDMP. But as the whole group is learning, the issue is not as simple as getting physicians to report prescriptions. NDMA's and physicians' voices are being heard, and the group is learning that mandatory reporting will not solve this issue.

In the almost six months that this group has been active, it is the view of NDMA that every party involved has learned something and has started to view their connection to the issue critically. The next steps from here might be challenging, but every move will be supported.

Overall, illicit prescription drug use in the state of North Dakota is minimal in comparison to some areas of the country, but that should not diminish the importance of tackling this issue. The legislators involved, as well as all represented groups, would like to see a proactive course of action while the problem is manageable.

If any physicians are interested in learning more about this taskforce or getting involved, please contact NDMA at 701-223-9475. ☺

Balancing Effective Pain Management with Prevention of Prescription Drug Abuse

Prescription drug abuse has reached crisis levels: overdoses and deaths from opioid analgesics have more than quadrupled in the U.S. since 1999. At the same time, a great deal of human pain and suffering remains inadequately treated. In fact, according to the Institute of Medicine, at least 100 million Americans suffer from chronic pain, creating an imperative to better prevent and manage persistent pain. As policymakers craft solutions to address prescription drug abuse, diversion, overdose, and death, it is critical that we do not unintentionally discourage physicians from appropriately treating pain or reduce access to prescription drugs for patients who are suffering.

The American Medical Association (AMA) has been working with the nation's state and specialty medical societies and many national organizations to identify and support workable solutions to curb prescription drug abuse, including the National Governors Association, Federation of State Medical Boards, and others. This also includes developing educational programs on pain management and prescription drug abuse. Although some chronic pain sufferers benefit from prescription opioids on a long term basis, many others do not benefit or suffer harm. A multidisciplinary approach is often needed to manage these patients and educational opportunities that focus on appropriate pain management can help ensure physicians have access to the information they need to properly and safely assess, treat, and monitor patients in pain.

Over the past decade, the AMA has offered a pain management Continuing Education Program (CME)ⁱ. This program has been recently updated

to provide physicians with up-to-date information on the assessment and management of pain. This CME series is a comprehensive educational resource comprised of 12 modules addressing numerous clinically important aspects of pain management. Subjects covered include:

- pain mechanisms and assessment
- an overview of management options
- the management of cancer and persistent non-cancer pain, including neuropathic pain
- the universal precautions approach to the clinical use of opioid analgesics
- the need to appropriately structure therapy and manage the risks associated with these substances
- pain management for specific populations, disorders or conditions

Funding for the program was made possible by support from the Prescribers' Clinical Support System for Opioid Therapiesⁱⁱ, a group of health care organizations led by the American Academy of Addiction Psychiatry that received grant funding from the Substance Abuse and Mental Health Services Administration.

The AMA offers physicians other educational resources to help combat prescription drug abuse and diversion. We are also continuing to develop a series of 12 free webinars for prescribers on various topics related to the intersection of addiction, pain management, and opioid use. Six webinars have already been held and are archived for on-demand viewingⁱⁱⁱ.

However, the availability of prescriber education alone will not solve this crisis. The AMA has advocated^{iv} that a public health based, multipronged approach



Ardis D. Hoven, MD, AMA President

and coordinated solutions are required. Essential elements include real-time prescriber access to patient prescription data, patient and caregiver education, proper storage and disposal of controlled substances, and targeted enforcement actions against "pill mills" and criminal activities contributing to diversion. Expanded use of drug courts would also be beneficial, as these courts can provide addicted patients with the medical attention, support and accountability needed to help achieve and sustain recovery.

Physicians often have difficulty finding and placing patients in addiction treatment and recovery programs. Regulatory burdens surrounding the use of buprenorphine and Suboxone[®] can make it difficult for physicians to successfully treat patients addicted to prescription drugs in an office-based setting. A far greater effort is needed on the treatment and recovery side of this crisis to help stem the tide of addiction, overdose, and death.

We will continue to work with policymakers to balance the physician's ethical obligation to treat patients who are suffering from pain against the need to identify drug seekers and prevent abuse, unintentional overdose, and death from prescription drugs. To learn more about efforts to combat prescription drug abuse and diversion, visit ama-assn.org/go/stopdrugabuse.

Membership in the AMA and your state medical society helps makes our work possible. **You can join the AMA or renew through NDMA by calling 701-223-9475.** §

As originally published on KevinMD.com

ⁱTo access the AMA's pain management continuing education program, visit <https://cme.ama-assn.org/Education.aspx>

ⁱⁱTo learn more about Prescribers' Clinical Support System for Opioid Therapies, go to <http://www.pcss-o.org/>.

ⁱⁱⁱTo access the on-demand archived webinars, go to <http://eo2.commpartners.com/users/ama/series.php?id=1214>

^{iv}To read AMA's letter to Senator Rockefeller, go to <http://www.ama-assn.org/resources/doc/washington/drug-abuse-and-diversion-letter-19oct2012.pdf>

SUPPORT NDMA PAC!

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

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

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



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sanfordhealth.org, keyword: eating disorders

IL, to RJ Kelley Herrick, LRD, Deborah Reeng, CNS, James Mitchell, MD, Michelle Jorgensen, MD, Stephen Winderlich, PhD, Lorraine Szabo-Kamman, PsyD, Kelly Kadlec, EdD, Kim LaRue, PhD, Tricia Myers, PhD

SCOFF Assessment

Use this recommended screening tool to help you determine if your patient needs eating disorders specialty care:

If your patient answers yes to two or more of these questions they should be referred for further evaluation by a qualified eating disorder professional

- Do you make yourself sick because you feel uncomfortably full?
- Do you worry you have lost control over how much you eat?
- Have you recently lost more than 15 pounds in a 3 month period?
- Do you believe yourself to be fat when others say you are too thin?
- Would you say food dominates your life?

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HEALTH

New App Allows for HIPAA-Compliant Texting



Few people need to be convinced of the advantages of texting. It may be the fastest and most efficient way of sending information in a given situation. Reports show that texting among physicians is widespread and that they are texting clinical information – whether it is legal to do so or not. Physicians who text each other clinical information risk exposing themselves to privacy and security violations of the Health Insurance Portability and Accountability Act (HIPAA.)

But a new smartphone app is changing all that.

Physicians now have the option to text each other patient information in a secure, HIPAA-compliant manner, thanks to an app called DocBookMD.

DocBookMD is a physician-only smartphone app that allows physicians to:

- Send HIPAA-compliant text messages and photos
- Assign an urgency setting to outgoing text messages
- Search a local pharmacy directory
- Search a local medical society directory (including email addresses and photos)
- Invite your staff to communicate with you through the app

“DocBookMD allows you to look up another doctor at the point of care. You can then either call the physician or send a text message with room numbers, medical record numbers, even pictures of wounds and x-rays. And all of this is sent securely and in a way that meets HIPAA requirements,” says Dr. Tim Gueramy.

DocbookMD Orientation Guide

Learning how to use DocbookMD is easy. Follow these steps and in minutes you'll know how to send secure messages and images to your colleagues.

1. Download DocbookMD

- a. Download the app to an iPhone, iPad or Android device from the App Store or Google Play.
- b. Click "I'm New To DocbookMD."
- c. Enter an email address and create a DocbookMD password.
- d. If the email used is not an email the medical society has on file, physicians will be asked to enter a medical society ID # to complete registration.



2. Send a message with a five-minute priority and attach an image

- a. Open "Messages" from the main menu.
- b. Tap the  icon in the top right corner to compose a new message.
- c. Look for a colleague that has the  icon next to their name.
- d. Type "Test" in the message body and then tap the  icon at the bottom of the screen to attach a photo from your photo album or take a new photo from within the app.
- e. Tap the  icon to assign a 5-minute priority, then press **Send** to send the message to your colleague.

3. Invite a colleague to use DocbookMD

- a. Browse the physician directory for a colleague you want to message, but who doesn't have a  icon next to their name.
- b. Open their profile and tap the "Send an Invitation" button.



DocbookMD is a FREE benefit of your medical society membership.



NDMA is proud to offer this application to all NDMA members. The app is up and running! We already have a couple dozen members signed on and we are working on spreading the word. Invite your colleagues and care team members to utilize the application today. In your app store on your smartphone or tablet, simply search for DocBookMD. From there, you can install it and say hello to secure communication. Download DocBookMD today!

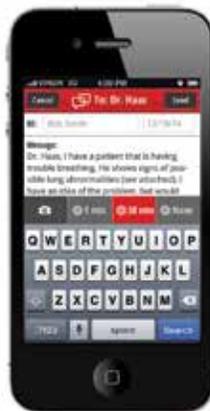


4. Invite a care team member to join you on DocbookMD

- Open the app from your mobile device.
- Click the Care Team tab in the main menu.
- Tap "Let's Get Started" if it's your first time or "Invite" if you're already started.
- Enter the first and last name of the person you want to invite and either their email address or mobile number.

5. Dictate a message and forward to a physician colleague or a member of your DocbookMD CareTeam

- Open a message from your inbox and press the  icon.
- Select a colleague you want to forward the message to.
- Tap the  icon at the bottom of the keyboard and dictate a short message to your colleague.
- Press "Send."



Dr. Gueramy, an orthopedic surgeon from Austin, Texas created DocBookMD with his wife, family physician Tracey Haas.

HIPAA-compliant text messaging

Message content can include patient information, such as diagnosis, test results, or medical history. Physicians can also add a high-resolution image of an EKG, an x-ray, lab report, or anything that can be photographed with a smart phone to the message. Messages can then be sent using the app's messaging priority system. Physicians can assign each message a 5-minute or 30-minute. "If the recipient does not answer the message within 5 minutes or if the message does not get to the doctor, you will then get a message back stating that it did not make it," says Dr. Gueramy. "You can see and hear that the message you receive is different from any other text."

All messages sent using DocBookMD meet HIPAA's requirements for encryption and the security of protected health information. This is accomplished through technology that keeps everything encrypted on the DocBookMD server. Messages are not downloaded to the phone, but are viewed from the phone. For added security, physicians are required to sign a HIPAA agreement before using DocBookMD. 



6. Set up Enhanced Notifications with your email and mobile number

- From the main menu, go to "Settings."
- Make sure "Enhanced Notifications" is switched to "on."
- Enter your email address and phone number and press "done."
- Now, in addition to an app alert, you'll be notified via a text message and email when you have a new DocbookMD message that has not been read in time.



Need help? Have comments? Contact us any time.

888.930.2048

support@docbookmd.com





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DocbookMD is a **free benefit** for NDMA members.

DocbookMD has now made it easier than ever to engage and communicate with your non-physician colleagues in a new feature to our app called Care Team. With Care Team, physicians can invite members of the patient care team to join them on DocbookMD to communicate in a secure, fast and efficient way through their mobile device. Now, all of those caring directly for patients can share messages and

images like X-rays, EKGs and images of wounds or rashes wherever and whenever they need to. Simply download the app from either the App Store or Google Play and start building your Care Team.



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



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NDMA
NORTH DAKOTA MEDICAL ASSOCIATION

CDL-CME Training Offered

The North Dakota Medical Association now offers convenient CDL-CME training from the comfort of your home or office. The Federal Motor Carrier Safety Administration (FMCSA) has established the National Registry of Certified Medical Examiners (NRCME), requiring all health care professionals who conduct physical examinations of interstate commercial motor vehicle drivers to:

- Complete training that is accredited by a nationally recognized medical profession accrediting organization to provide continuing education units and meets the FMCSA standards
- Pass a certification exam to demonstrate that the medical examiner is qualified and competent to conduct physical examinations of drivers who wish to obtain their interstate Commercial Driver's License (CDL)
- Maintain competence by periodic training and testing

Beginning May 21, 2014, the FMCSA will accept only medical examiners' certificates issued by medical examiners listed on the National Registry of Certified Medical Examiners (NRCME). These requirements support FMCSA's goal to improve safety and reduce fatalities on our nation's highways.

In response to this new federal requirement, the North Dakota Medical Association is now 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. Upon completing the training, participants will be prepared and qualified to take the NRCME certification exam.

There are training courses available from numerous organizations; however, NDMA has eliminated the need to research the various programs before

you decide. NDMA's course is 100% online (conducted at your own pace) with the option to obtain AMA PRA Category 1 Credits™ (approved for 9.5 AMA PRA Category 1 Credits™). Other non-member health care professionals can also enroll in our training course; however, NDMA members receive a discounted rate.

Training includes:

- Suggestions/references to pre-course reading/reference materials
- Ability to start/stop/pause training according to your schedule
- Six months unlimited 24/7 access from your PC, laptop, iPhone, iPad, or other mobile device
- Printable course materials
- Case studies/reviews and steps to prepare for the certification exam
- Course certificate immediately upon completing the course
- Options to register and receive CME credit or register at a reduced price which does not include CME credit

Visit the website ndmaessentialeducationwebinarnetwork.com/ to register today! You can also view this information on NDMA's website. Please call the NDMA office at 701-223-9475 if you have any questions. ❧

Beginning May 21, 2014, the FMCSA will accept as valid from CDL drivers only medical examiners' certificates issued by medical examiners listed on the National Registry of Certified Medical Examiners (NRCME).

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Mandatory Reporting of Abuse or Neglect of Vulnerable Adults

Note: This information is available online at www.nd.gov/dhs/services/adultsaging/reporting.html
To receive the most up to date information on this issue, please refer to the above website for updates.

On April 24, 2013, SB 2323, the mandatory reporting of abuse or neglect of vulnerable adults, was signed into law and on August 1, 2013, the law went into effect. These listed professionals are required to report abuse, neglect, and exploitation of vulnerable adults:

- Clergy (note: not required if knowledge is gained as a spiritual advisor)
- Addiction counselor
- Caregiver
- Chiropractor
- Congregate care personnel
- Dental Hygienist
- Dentist
- Emergency medical personnel
- Family Therapist
- Firefighter
- Hospital personnel
- Law enforcement officer
- Marriage Therapist
- Medical examiner
- Mental health professional
- Nurse
- Nursing home personnel
- Occupational Therapist
- Optometrist
- Pharmacist
- Physical Therapist
- Physician
- Podiatrist
- Social Worker
- Other professionals
- Any other person may voluntarily report to the North Dakota Department of Human Services or to law enforcement

A mandated reporter must report if in an official or professional capacity, he or she has knowledge that a vulnerable adult has been subjected to abuse or neglect or observes a vulnerable adult being subjected to conditions or circumstances that reasonably would result in abuse or neglect. **A mandated reporter is required to report as soon as possible.** Failure to report abuse or neglect can result in a fine up to \$1000.

In order to comply, a reporter must complete and submit a reporting form and follow the guidelines and flow charts provided on DHS's website to file the report with the appropriate entity. In the report, include, to a reasonable

extent, the name, age, and residence of the alleged vulnerable adult; the nature and extent of the alleged abuse or neglect or the conditions and circumstances that would reasonably be expected to result in abuse or neglect; any evidence of previous abuse or neglect; and any other information that, in the reporter's opinion, may be helpful in establishing the cause of the alleged abuse or neglect and the identity of the individual responsible for the alleged abuse or neglect.

This information was provided by the Department of Human Services website: www.nd.gov/dhs/services/adultsaging/reporting.html.

The North Dakota Department of Human Services created an educational fact sheet to help you as you learn the ins and outs of this new law and we included it here for your reference. For more information, please contact Michelle Gayette, MGMT/LAC, Elder Rights Program Administrator of the Aging Services Division at 701-328-4613. §



SB 2323 outlined the mandatory reporting of vulnerable adult abuse and this important piece of legislation was signed into law by the Governor on April 24, 2013. Cher Meyer, a concerned citizen of District 20 introduced this matter to Senator Phil Murphy when he was campaigning door to door in the fall of 2012. Senator Murphy, along with Senator Mathern and Representative Guggisberg, championed this bill throughout the session. To learn more about SB 2323, visit the North Dakota Legislation site, www.legis.nd.gov.

Pictured with Gov. Jack Dalrymple (center) are (front) Senator Phil Murphy, District 20; and Cher Meyer; (back) Senator Tim Mathern, District 11; Kim Jacobson, Traill County Social Services Director; Representative Ron Guggisberg, District 11; and Courtney M. Koebele, NDMA Executive Director.

Vulnerable Adult Protective Services Program

What is the Vulnerable Adult Protective Services Program?

- The program addresses the safety of vulnerable adults who are at-risk of harm due to the presence or threat of **abuse, neglect, or exploitation**.
- The program is offered statewide through the N.D. Department of Human Services' regional human service centers or through local partner agencies.

What is abuse and neglect of a vulnerable adult?

- **Abuse** means any willful act or omission of a caregiver or any other person which results in physical injury, mental anguish, unreasonable confinement, sexual abuse or exploitation, or financial exploitation to or of a vulnerable adult.
- **Neglect** means the failure of a caregiver to provide essential services necessary to maintain the physical and mental health of a vulnerable adult, or the inability or lack of desire of the vulnerable adult to provide essential services necessary to maintain and safeguard the vulnerable adult's own physical and mental health.
- **Vulnerable adult** means an adult who has a substantial mental or functional impairment.
 - **"Substantial functional impairment"** means a substantial incapability, because of physical limitations, of living independently or providing self-care as determined through observation, diagnosis, evaluation, or assessment.
 - **"Substantial mental impairment"** means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, or ability to live independently or provide self-care as revealed by observation, diagnosis, evaluation, or assessment.

Additional definitions are found in North Dakota Century Code section 50-25.2-01 available at www.legis.nd.gov/cencode/t50c25-2.pdf?20130702181453.

Who does the program serve?

- The program is offered to vulnerable adults age 18 and older or to a minor emancipated by marriage with substantial mental or functional impairments which affect their health, safety, or independence.

Who can call with a concern about possible abuse, neglect, or exploitation?

- A medical or mental health professional providing care or services to a vulnerable adult who has

knowledge that a vulnerable adult has been subjected to abuse or neglect is required to report.

- Anyone can call with a concern including a friend, relative, neighbor, banker, or other concerned community member.

Who do I contact to report a concern?

- Contact one of the following offices to reach Vulnerable Adult Protective Services or law enforcement.

Region Contact Name Phone Toll-Free Fax E-mail

REGION	CONTACT NAME	PHONE	TOLL-FREE	FAX	E-MAIL
Bismarck	Katie Schafer	701-328-8868	888-328-2662	701-328-8900	kkschafer@nd.gov
Devils Lake	Kim Helten	701-665-2269	888-607-8610	701-665-2300	khelten@nd.gov
Dickinson	Rene Schmidt	701-227-7582	888-227-7525	701-227-7575	rschmidt@nd.gov
Fargo	Cass Co. Social Services	701-241-5747 Option #3		701-239-6820	
Grand Forks	Bernie Hopman	701-795-3066	888-256-6742	701-795-3050	bfhopman@nd.gov
Jamestown	Danelle Van Zinderen	701-253-6396	800-260-1310	701-253-6400	dvanzinderen@nd.gov
Minot	Niels Anderson	701-629-5393	701-628-2925	701-628-3175	nanderson@co.mountrail.nd.us
Williston	Kayla Fenster	701-774-4685	800-231-7724	701-774-4620	kfenster@nd.gov

- **Urgent:** If a vulnerable adult is in immediate danger, call law enforcement now and then one of the numbers listed above.

What happens after I make a call?

When a call about possible abuse or neglect is received, an adult protective services staff member:

- Reviews your concern by asking screening questions over the phone to determine if the adult is in serious danger and in need of immediate intervention (such as law enforcement).
- Conducts a home visit to complete an assessment and make an appropriate referral.

What else should I know after I call with a concern?

- A person, including a vulnerable adult, has the right to make his or her own decisions unless the person gives up that right or the court system gives that responsibility to someone else.
- A person, including a vulnerable adult, has the right to live how he or she wants if it does not harm others or involve a crime.
- If a vulnerable adult who is subject to abuse or neglect is unable to consent to and accept adult protective services, or if that vulnerable adult's caregiver refuses adult protective services, the department can independently pursue legal action necessary to protect the vulnerable adult from further abuse or neglect. (NDCC 50-25.2-07)

Additional Resources

ND Aging and Disability Resource LINK
Toll Free: 1-855-GO2-LINK (1-855-462-5465)
www.carechoice.nd.gov

A Recap of NDMA's 126th Annual Meeting: *The Future of Medicine*

We are pleased to report that NDMA hosted another successful Annual Meeting. Over 55 physicians, guests, award recipients, and staff attended the 126th meeting in Fargo at the Ramada Plaza Suites and Conference Center. We were honored by the presence and presentations of our guest speakers and education they provided, which offered 4 hours of CME credit to all participants.

Dr. Susan Bailey, MD, and representative of the AMA Board of Trustees, attended the NDMA Council meeting and presented an AMA update to the House of Delegates. Dr. Bailey's presentation, "Shaping a Better Future for Patients, Medical Students and Physicians," reviewed AMA's strategic plan and goals for the next five years. Those goals include improving health outcomes for patients, accelerating change in medical education, and increasing physician satisfaction by shaping more effective payment and delivery models.

Dr. Lyle Thorstensen, North Dakota native and AMPAC board of Trustees member, attended both the council meeting and the House of Delegates, where he delivered an AMPAC update. Dr. Thorstensen emphasized the importance of contributing to AMPAC and NDMA PAC, as both entities work diligently to get more physician-friendly candidates elected and advance a medicine-friendly advocacy agenda.

Dean Joshua Wynne, MD, MBA, MPH, the University of North Dakota's vice president for health affairs and dean of the UND School of Medicine and Health Sciences, presented an update on the School of Medicine and progress on the Healthcare Workforce Initiative. Dean Wynne expressed his gratitude toward North Dakota physicians for contributing their time to North Dakota's medical students. His column in this issue delves into his talking points of that day.

Timothy L. Bartholow, MD, Chief Medical Officer Wisconsin Medical Society, was the primary presenter for NDMA's CME program. In his presentation, "Understanding Overall Health Care Expenses in the National Economy: the Race to Value," Dr. Bartholow covered the difficult financial issues facing medicine today. He explored the financial impact of coordination of care as a substantial solution to health care spending. This presentation provided a greater awareness of costs and their impact on access to care.

We kept Dr. Bartholow working for a third hour as moderator of the fourth CME segment, the Payor Panel on Health Care Reform. Panelists were: Eunah K. Fischer, MD, Chief Medical Officer, BCBSND; Lisa Carlson, Director of Planning and Regulations, Sanford; and Julie F. Schwab, Director of North



From left, Dr. A. Michael Booth, 40-year service recognition recipient Dr. Steffan P. Christensen, and NDMA Executive Director Courtney Koebele, JD



NDMA Past-President Dr. Kimberly Krohn with Dr. John and Mrs. Elise Leitch

Dakota Medicaid Services. The panel was particularly timely because the opening of the new health care marketplace had happened just two days prior. The panelists covered issues including:

- How the ACA is affecting payors
- How payors are participating in the insurance marketplace
- New issues that physicians should be aware with regard to their organization

Questions from the audience steered the expert-led conversation and provided a wider understanding of the payor perspective.

Paul Von Ebers, President and CEO, Nordian Mutual Insurance Company, gave an update on the progress of the Affordable Care Act as the luncheon keynote speaker. Mr. Von Ebers candidly answered questions from the audience regarding the ACA's effect on Blue Cross, the current status of Blue Cross, as well as current issues facing individual physician practices.

The House of Delegates reviewed the seven presented resolutions; five were adopted. Resolution #4 was referred to the NDMA Commission on Ethics and Resolution #7 will be submitted to the AMA for action and referred to the NDMA Commission on Socio Economics. We included the full script on each of the resolutions in this issue for easy reference.

Besides all the learning, there was fun to be had. The Annual Social and Dinner was fantastic and aside from the awards and recognition, it featured musical entertainment from Poco Fuego, a steel drum band from Minnesota State University-Moorhead. We honored our physicians who hit the 40-year mark in practice, including Ferdinand E.K. Addo, MD; Utpal Chakravorty, MD; Steffan P. Christensen, MD; Charles E. Christianson, MD; Thomas C. Corbett, MD; Jonathan L. Dickson, MD; Douglas L. Greves, MD; Robert E. Grossman, MD; Danuta Komorowska, MD; Anthony J. Kotnik, MD; Raymond L. Larsen, MD; John M. Leitch, MD; Ralph Levitt, MD; Dennis J. Lutz, MD; Lucy B. Malkasian, MD; Kent Martin, MD; Thomas W. Mausbach, MD; Mark Siegel, MD; and Frank A. Thorngren, MD.



Dr. John Leitch of Sanford Health Roger Maris Cancer Center with his Physician Community and Professional Services Award at the 2013 NDMA Annual Meeting



Dan Kelly, Chief Executive Officer of McKenzie County Healthcare Systems, with his Friend of Medicine Award at the 2013 NDMA Annual Meeting



Dr. Steven Strinden presenting Dr. A. Michael Booth with a Medal of Recognition after reading the resolution that resolved "the House of Delegates of the NDMA enthusiastically expresses its gratitude and appreciation to President Michael Booth"



Dr. Timothy Bartholow moderating the Payor Panel on Health Care Reform. The panel members from left: Lisa Carlson, Director of Planning and Regulations, Sanford; Dr. Eunah Fischer, Chief Medical Officer, BCBSND; and Julie Schwab, Director of North Dakota Medicaid Services

Our Physician Community and Professional Services Award recognition was awarded to Dr. John Leitch of the Sanford Health Roger Maris Cancer Center in Fargo. The award recognizes outstanding members of the Association who actively serve as role models, in both their profession and community. Dr. Leitch has been a physician leader involved in improving the screening and prevention, treatment, and delivery of cancer care to patients with cancer in North Dakota. Dr. Leitch was nominated by Kathy Hanish, RN, MS, of Sanford Health in Fargo. Ms. Hanish nominated Dr. Leitch for this award because he exemplifies “integrity, devotion, and personal commitment to improve the health of citizens of North Dakota.” Furthermore, Ms. Hanish went on to add that Dr. Leitch’s “leadership as Chair of the Roger Maris Cancer Committee for the past 13 years led to the improvement and delivery of cancer care in

this region where survival rates for the top five cancers exceed the average in the nation.”

Dan Kelly, Chief Executive Officer of McKenzie County Healthcare Systems, was recognized with NDMA’s Friend of Medicine award. The award formally acknowledges non-physician citizens of the state who “have distinguished themselves by serving as effective advocates for health care, patient services, or the profession of medicine in the state of North Dakota.” Mr. Kelly has over 20 years of experience in health care administration, in both the for-profit and non-profit sectors, and is active in a number of health and community related initiatives. Dr. Gary Ramage, a physician at McKenzie County Healthcare Systems, nominated Mr. Kelly for this award. Dr. Ramage’s nomination letter’s noted that “Dan Kelly takes great pride in his role in the healthcare community in North Dakota... In this time of great expansion of the need for medical services in western North Dakota, Dan has led the charge in serving patients with quality healthcare.”

Dr. A. Michael Booth, the outgoing president of NDMA, hosted the evening and at its close, was recognized for his tireless and dedicated service to NDMA. We are so lucky to have such a strong history of leadership in this organization, and the future looks just as promising. Incoming NDMA President Dr. Steven P. Strinden presented Dr. Booth with a medal of recognition of his service and read a resolution of recognition.

We understand that participating in the Annual Meeting can be difficult to manage, but those that attended found the investment of time worth the effort. With many complicated issues facing the practice of medicine, talking with others in the field and gaining greater perspective from outside entities proved fruitful for all attendees. We are working on 2014’s Grand Forks Meeting, including an updated format which might allow for more individuals to make the meeting work for their schedules. Stay tuned for updates and information! §

Dr. Debra Geier, elected to be NDMA Council Vice President at the 2013 Annual Meeting after serving as Secretary-Treasurer for the past two years, leading a discussion at the NDMA Council with Jen Lee, of AMA’s Federation Relations



RESOLUTION NO. 1

Introduced By: A. Michael Booth, MD
Subject: Gun Safety

- 1) **WHEREAS**, gun violence is a major public concern because it is one of the leading causes of injury and death in the United States, and
- 2) **WHEREAS**, in 2009 the United States had a population of 307 million people, and
- 3) **WHEREAS**, based on production data from firearms manufacturers, there are roughly 300 million firearms owned by civilians in the United States as of 2010; of which almost 100 million are hand guns, and
- 4) **WHEREAS**, roughly 16,272 murders were committed in the United States during 2008, of which almost 10,886 or 67 percent were committed with firearms, and
- 5) **WHEREAS**, according to a report from the Institute of Medicine, in 2010, more than 105,000 people were injured or killed in the United States as the result of a firearm-related incident; and
- 6) **WHEREAS**, AMA H-145.978 (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed; and
- 7) **WHEREAS**, many health professional groups have advocated a prevention-based strategy to decrease gun shootings, and
- 8) **WHEREAS**, the same evidence based approach that is saving millions of lives from motor vehicle accidents, smoking, cancer and aids, can reduce death and injuries from gun violence, and
- 9) **WHEREAS**, monitoring the scope and nature of a problem is the first step of any public health approach, and
- 10) **WHEREAS**, there is little publicly funded research for firearm injuries and death.

THEREFORE, BE IT RESOLVED BY THE 2013 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION 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

BE IT FURTHER RESOLVED that NDMA encourage the development and presentation of gun safety programs that educate the public on the responsible use and storage of firearms; and

BE IT FURTHER RESOLVED 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.

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

RESOLUTION NO. 2

Introduced By: NDMA Council
Subject: Prescription Drug Monitoring Program

- 1) **WHEREAS**, the 2007 North Dakota Legislative Assembly enacted legislation establishing a prescription drug monitoring program (PDMP) and placed it in the State Board of Pharmacy; and
- 2) **WHEREAS**, the North Dakota Medical Association has been a supporter of the PDMP program from its inception, and encourages members through communications and outreach to participate to the fullest extent within their practices; and
- 3) **WHEREAS**, a prescription filled in a non-federal facility may take 24 to 48 hours to appear in a PDMP report and federal facilities report on a weekly basis. Some out-of-state pharmacies can obtain a waiver to report weekly or monthly depending on the volume of prescriptions dispensed per year; and
- 4) **WHEREAS**, the efficacy of a PDMP is diminished by not providing information on a “real-time” basis; and
- 5) **WHEREAS**, the current PDMP requires a separate login from the physician’s electronic health record (EHR) system; and
- 6) **WHEREAS**, the use of the PDMP would increase if it was integrated within the EHR of physicians’ practices; and
- 7) **WHEREAS**, the purpose of the PDMP is to provide timely and useful information to both licensed prescribers and pharmacists and help health care practitioners identify patients who may need treatment for drug abuse or addiction; and
- 8) **WHEREAS**, the issue of prescription drug abuse has been identified as a major public policy issue by the North Dakota legislature; and
- 9) **WHEREAS**, as of 2013 there are approximately 1660 physicians practicing in North Dakota (MDs and DOs) and currently about 450 physicians are registered to use the PDMP;

THEREFORE, BE IT RESOLVED BY THE 2013 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION 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 interoperability with EHRs currently used by physicians, both in North Dakota and nationally; and

BE IT FURTHER RESOLVED, NDMA opposes 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

BE IT FURTHER RESOLVED, 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 enrollment of prescribers in the PDMP at the time of license renewal; and

BE IT FURTHER RESOLVED, that NDMA continue its strong endorsement of the PDMP and encourage all physicians to utilize it within their practices; and

BE IT FURTHER RESOLVED, 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.

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

RESOLUTION NO. 3

Introduced By: Michael Booth, MD
Subject: Independent Payment Advisory Board (IPAB)

- 1) **WHEREAS**, Section 3403 of the Patient Protection and Affordable Care Act (ACA) established the Independent Payment Advisory Board (IPAB) consisting of 15 members appointed to six-year terms, and charged it with the reduction of spending in Medicare by reducing payments to medical professionals; and
- 2) **WHEREAS**, Twelve IPAB members will be appointed by the President, and practicing medical professionals, including physicians, are prevented from membership; and
- 3) **WHEREAS**, The decisions of IPAB cannot be challenged in the courts and are freed from the normal administrative rules process, such as requirements for public notice, public comment or public review; and
- 4) **WHEREAS**, IPAB recommendations carry the full force of the law, and will be very difficult for Congress to override unless 3/5 of the Senate and a majority of the House vote to do so; and
- 5) **WHEREAS**, The IPAB board is specifically forbidden from “any recommendations to ration health care,” but ACA fails to define the word “ration.” Instead, it allows IPAB to pay physicians reimbursement rates below costs, which in essence would constrict a physician’s ability to treat patients; and
- 6) **WHEREAS**, Medicare-eligible seniors and others already have difficulty finding medical professionals to treat them.

THEREFORE, BE IT RESOLVED BY THE 2013 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION, that NDMA believes it is not in the best interest of the state, or Medicare-eligible residents of the state, for the Independent Payment Advisory Board to be implemented because its decisions will most certainly limit patient access to quality medical care; and

BE IT FURTHER RESOLVED that NDMA 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.

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

RESOLUTION NO. 4

Introduced By: First District Medical Society
Subject: Disrespect and Derogatory Conduct in the Patient-Physician Relationship

- 1) **WHEREAS**, the relationship between patients and physicians is based on trust and should serve to promote patients’ well-being while respecting their dignity and rights. Trust can be established and maintained only when there is mutual respect; and
- 2) **WHEREAS**, derogatory language or actions on the part of physicians can cause psychological harm to those they target.

Also, such language or actions can cause reluctance in members of targeted groups to seek or to trust medical care and thus create an environment that strains relationships among patients, physicians, and the health care team. Therefore, any such conduct is profoundly antithetical to the Principles of Medical Ethics; and

- 3) **WHEREAS**, Patients who use derogatory language or otherwise act in a prejudicial manner toward physicians, other health care professionals, or others in the health care setting, seriously undermine the integrity of the patient-physician relationship; and
- 4) **WHEREAS**, there is the importance of recognizing the patient’s right to choose his or her physician, the importance of ensuring that each patient has an identified physician responsible for the patient’s care, appropriate institutional mechanisms to address abusive behavior by patients, appropriate psychiatric referral or consultation as part of the treatment plan if the derogatory conduct is a consequence of a mental disorder, and an appropriate mechanism to ensure continuity of care for a patient who persistently declines care from the responsible practitioner/attending physician; and
- 5) **WHEREAS**, the American Medical Association has affirmed these principles in Ethical Opinion E-9.123, “Disrespect and Derogatory Conduct in the Patient-Physician Relationship.”

THEREFORE, BE IT RESOLVED BY THE 2013 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION 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.

Referred to the NDMA Commission on Ethics
October 4, 2013
Debra Geier, MD
Acting Speaker of the House

RESOLUTION NO. 5

Introduced By: NDMA Council
Subject: Physician-Led, Team Based Care

- 1) **WHEREAS**, the term “team-based health care” is defined by the AMA as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care; and
- 2) **WHEREAS**, the effectiveness, safety, and efficiency of primary and specialty care delivered by physician-led health care teams have been well documented, and such physician-led teams can most appropriately expand access to care, as will be necessitated under health care reform; and
- 3) **WHEREAS**, physicians have extensive, in-depth training and experience in the accurate diagnosis and proper management of a broad range of diseases; and
- 4) **WHEREAS**, AMA policy calls for team-based health care to be physician-led to assure optimal safety and quality of care for patients; and

- 5) **WHEREAS**, as leaders, physicians are responsible to foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information and resources; and
- 6) **WHEREAS**, this collaboration and consultation can take place through telemedicine, allowing team members to work in locations separate from their team physician (e.g., nursing homes, free clinics in medically underserved areas); and
- 7) **WHEREAS**, there has been legislation in other states that includes criteria that defines successful physician-led team-based models of care.

THEREFORE, BE IT RESOLVED BY THE 2013 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION that NDMA work with North Dakota state lawmakers and regulators to ensure patient-centered medical homes are physician-led.

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

RESOLUTION NO. 6

Introduced By: NDMA Council
Subject: Raise North Dakota's Tobacco Tax

- 1) **WHEREAS**, tobacco use remains North Dakota's leading preventable cause of death, killing more people than alcohol, AIDS, car crashes, illegal drugs, murders, and suicides combined; and
- 2) **WHEREAS**, 19.4% (7,400) of youth in North Dakota smoke, and 500 North Dakota kids (under 18) become new daily smokers each year, of whom more than 11,000 will die prematurely because of this addiction; and
- 3) **WHEREAS**, 21.9% (116,600) of adults in North Dakota smoke and nearly 800 North Dakotans will die each year from smoking and smoking-related disease; and
- 4) **WHEREAS**, tobacco use in North Dakota imposes economic burden, with smoking-caused direct-healthcare costs amounting to \$247 million each year, smoking-caused productivity losses approximating \$192 million annually, and each household paying \$574 per year in state and federal taxes from smoking-caused government expenditures; and
- 5) **WHEREAS**, each year, the North Dakota government Medicaid payments directly related to tobacco use is \$47 million; and
- 6) **WHEREAS**, the current cigarette tax of \$0.44 per pack, pipe tobacco and cigar tax at 28% of the wholesale purchase price, and snuff tax at \$0.60 per ounce, ranking North Dakota one of the four cheapest tobacco states in the nation, is dangerous to our state's citizens; and
- 7) **WHEREAS**, the legislative body in North Dakota has not enacted legislation to increase our state's tobacco taxes in 20 years, since 1993; and
- 8) **WHEREAS**, according to the 2012 US Surgeon General's Report, increasing tobacco excise taxes have proven highly effective

in preventing initiation among youth, reducing tobacco use by promoting cessation among current users, discouraging relapse among former users, and reducing consumption among those who continue to use tobacco.

THEREFORE, BE IT RESOLVED BY THE 2013 HOUSE OF DELEGATES OF THE NORTH DAKOTA MEDICAL ASSOCIATION, as a proven way to prevent youth tobacco initiation, encourage a reduction of adult tobacco use, reduce health care costs, and provide an overall benefit to public health, 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, with the increased amount to be dedicated to funding of elementary and secondary education in this state.

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

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

NDMA Signs Letter to Bring Awareness to the Effects of the Sunshine Act

On October 28, 2013, NDMA, along with 40 other state medical organizations and 33 other professional medical organizations, signed this letter to Secretary of Health and Human Services, Kathleen Sebelius.

Dear Secretary Sebelius:

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.

The Sunshine Act was designed to promote transparency with regard to payments and other financial transfers of value between physicians and the medical product industry. As part of this provision, Congress outlined twelve specific exclusions from the reporting requirement, including “[e]ducational materials that directly benefit patients or are intended for patient use.” In its interpretation of the statute, CMS concluded that medical textbooks, reprints of peer reviewed scientific clinical journal articles and abstracts of these articles are “not directly beneficial to patients, nor are they intended for patient use.” We believe this conclusion is inconsistent with the statutory language on its face, congressional intent, and the reality of clinical practice where patients benefit directly from improved physician medical knowledge.

The importance of up-to-date, peer reviewed scientific medical information as the foundation for good medical care is well documented. Scientific peer-reviewed journal reprints, supplements, and medical text books have long been considered essential tools for clinicians to remain informed about the latest in medical practice and patient care. Independent, peer reviewed medical textbooks and journal article supplements and reprints represent the gold standard in evidence-based medical knowledge and provide a direct benefit to patients because better informed clinicians render better care to their patients. Moreover, Congress included a specific exclusion of items that directly benefit patients, such as reference materials that are often used side-by-side with a patient as a first resource when a patient brings an unfamiliar medical issue to a clinician. Many medical textbooks & scientific medical journal supplements and reprints are used in this way by physicians. The design of the reporting requirement presents a clear disincentive for clinicians to accept high quality, independent educational materials; an outcome that was unintended when the provision was passed into law.

The Food and Drug Administration (FDA)'s 2009 industry guidance titled “Good Reprint Practices for the Distribution of Medical Journal Articles and Medical or Scientific Reference Publications on Unapproved New Uses of Approved Drugs and Approved or Cleared Medical Devices” underscores the importance of this scientific peer reviewed information. The FDA noted the “important public health and policy justification supporting dissemination of truthful and non-misleading medical journal articles and medical or scientific reference publications.” FDA guidelines for reprints provide that medical reprints should be distributed separately from information that is promotional in nature, specifically because the reprints are designed to promote the science of medicine, are educational, and intended to benefit patients. We believe the Sunshine Act was designed to support the dissemination of this type of educational material.

We are concerned that the final regulations could inadvertently prevent the timely distribution of rigorous scientifically reviewed medical information to clinicians and patients and thereby undermine efforts to improve the quality of care provided to patients. This was not the intent of Congress when they passed the Sunshine Act as evidenced by the statutory language. We request that you reverse this policy and place textbooks and scientific peer reviewed medical journal reprints, supplements, and abstracts among the items excluded from the Sunshine Act's reporting requirements. As clinicians, patients and providers of health care we know that these materials provide a direct benefit to patients and are critical for patient care.

Sincerely,

- American Academy of Child and Adolescent Psychiatry
- American Academy of Facial Plastic and Reconstructive Surgery
- American Academy of Family Physicians
- American Academy of Neurology
- American Academy of Otolaryngology-Head and Neck Surgery
- American Association of Clinical Endocrinologists
- American Association of Neurological Surgeons/ Congress of Neurological Surgeons
- American Association of Orthopaedic Surgeons
- American Association for Geriatric Psychiatry
- American College of Cardiology
- American College of Emergency Physicians
- American College of Radiology
- American College of Rheumatology
- American Geriatrics Society
- American Medical Association
- American Medical Directors Association
- American Podiatric Medical Association
- American Psychiatric Association
- American Society of Anesthesiologists
- American Society for Clinical Oncology
- American Society for Clinical Pathology
- American Society for Dermatologic Surgery Association
- American Society for Gastrointestinal Endoscopy
- American Society of Nephrology
- American Society of Nuclear Cardiology
- American Thoracic Society
- American Urological Association
- Endocrine Society, The
- Heart Rhythm Society
- Infectious Diseases Society of America
- International Society for the Advancement of Spine Surgery
- Medical Group Management Association
- Society for Vascular Surgery
- Arizona Medical Association
- California Medical Association
- Colorado Medical Society
- Connecticut State Medical Society
- Medical Society of Delaware
- Medical Society of the District of Columbia
- Florida Medical Association
- Medical Association of Georgia
- Hawaii Medical Association
- Illinois State Medical Society
- Iowa Medical Society
- Kansas Medical Society
- Kentucky Medical Association
- Louisiana State Medical Society
- Maine Medical Association
- MedChi, The Maryland State Medical Society
- Massachusetts Medical Society
- Michigan State Medical Society
- Minnesota Medical Association
- Mississippi State Medical Association
- Missouri State Medical Association
- Montana Medical Association
- Nebraska Medical Association
- Nevada State Medical Association
- New Hampshire Medical Society
- Medical Society of New Jersey
- New Mexico Medical Society
- Medical Society of the State of New York
- North Dakota Medical Association
- Ohio State Medical Association
- Oregon Medical Association
- Pennsylvania Medical Society
- South Carolina Medical Association
- South Dakota State Medical Association
- Tennessee Medical Association
- Texas Medical Association
- Vermont Medical Society
- Medical Society of Virginia
- Washington State Medical Association
- West Virginia State Medical Association
- Wyoming Medical Society

Quiet Anniversaries That Resound Loudly with North Dakotans

With all the chaos and busy-ness in our everyday lives, milestones like birthdays and anniversaries pass by so quickly that, once in a while, we forget to celebrate the day itself, let alone the importance that occasion brought to our lives. There were two anniversaries that just passed on the calendar, and while we are not upset, as a spouse or child might be upon being forgotten, we thought the occasions provided a great opportunity to remind NDMA members of the progress North Dakota has made in the past five years in tobacco prevention and control.

November 4 and November 6 marked, respectively, the anniversaries of the passages of Measure #3 in 2008 and Measure #4 in 2012. Measure #3 received 54% of the vote and thus implemented and fully funded North Dakota's comprehensive tobacco prevention and control program. Measure #4 earned 67% approval at the polls and created the strongest statewide smoke-free law in the nation.

These publicly (rather than legislatively) initiated and passed measures have a direct impact on the health of North Dakotans and support for each has only grown stronger since their passages. In February of 2013, Tobacco Free North Dakota (TFND) commissioned a public poll of North Dakota voters, conducted by Keating Research, Inc., to gauge the public's feelings toward the aforementioned measures. Results showed support for continuing to fund a comprehensive program had grown from 54% of the voters in 2008 to 89% of those polled, and the statewide smoke-free law, just three months into its implementation, had already reached 72% support, up from 67% of voter support. It is difficult to argue

with numbers like that, and it is even more difficult to argue with the effects produced by policies like these.

Medical professionals know of, and many educate, about the harmful role tobacco use plays in the health of their patients and future patients. TFND has great respect and overwhelming appreciation for the tobacco prevention and cessation efforts our medical professionals practice in their offices. In fact, a recent study showed that physicians and other medical professionals are the best and most effective messengers for advising individuals to quit tobacco use. Though obesity has climbed the ranks, tobacco use still remains one of the leading causes of preventable disease and death, contributing to more than 800 deaths each year right here in North Dakota. Reducing, and even better yet, preventing, tobacco use provides the greatest benefits in reducing the incidences of so many chronic diseases – from lung cancer and diabetes to heart disease and stroke.

While the health benefits of reducing and preventing tobacco use are fairly obvious, a topic often overlooked when discussing the impacts of successful tobacco prevention is the potential savings in annual health care costs. In North Dakota, annual health care costs directly caused by smoking alone is estimated at \$247 million, and smoking-related costs covered by the state Medicaid program total \$47 million annually. If we, as a nation, and in North Dakota, as a fiscally conservative state, are truly concerned with bringing down our health care costs, we would double-down on tobacco prevention efforts.



Erin Hill-Oban, Executive Director
of Tobacco Free North Dakota



According to the Centers for Disease Control (CDC), best practices for comprehensive tobacco control programs is a three-legged stool: 1.) fully-funding the program at CDC recommendations; 2.) implementing strong smoke-free laws; and 3.) passing high tobacco tax rates. North Dakota is one of very few states to successfully enact two of the three, but with a dangerously low tobacco tax, ranking 46th lowest in the nation, North Dakota will struggle to bring tobacco use down much further. Although an obvious source of revenue, we view tobacco tax as a public health measure to reduce tobacco use and save millions in future health care costs. Proven as one of the most effective ways to prevent young people from ever starting and to encourage current users to quit or reduce use, raising the tobacco tax is a lofty, yet achievable goal that organizations like TFND are dedicated to addressing through legislative action in 2015.

Years of research show time and time again the indisputable effects that tobacco prevention and control policy has on public health, so your work in the doctor's office, combined with TFND and NDMA's efforts on statewide policy, are certainly making a difference. We are grateful to your organization for your past support, commend you for going on record with us by adopting a resolution of support to raise North Dakota's tobacco tax, and look forward to opportunities to provide information and education to your members, the public, and policymakers throughout the coming year. §

Though obesity has climbed the ranks, tobacco use still remains one of the leading causes of preventable disease and death, contributing to more than 800 deaths each year right here in North Dakota.

North Dakota: Trauma Update and Orthopaedic Injuries Between 2007-2011

Summary:

The population of North Dakota over the past five years has increased. The North Dakota Trauma Registry has recorded an increase in number of trauma cases, as well as orthopaedic extremity and spine injuries. With respect to trauma, while all age groups have demonstrated an increase, most notably are those in the 25-34 and 45-54 year olds. Comparing males to females, the largest increase is: males 25-34 and 45-54 year olds. In females, the largest increase is seen in women 75 and above. The distribution of increase appears to be in the Western Regions where activity has been most active with the oil boom. The trauma centers in North Dakota (levels II, IV and V) continue to improve in healthcare response and delivery in a state that continues to attract a population responding to the bright economic future associated with the oil boom.



Laura M. Bruse Gehrig MD, FAAOS, CCD
Orthopaedic Surgeon
Sanford Orthopaedics and
Sports Medicine, Bismarck ND

Lindsey B. Narloch,
MS Emergency Management, Research Analyst
North Dakota Department of Health, Division of
EMS and Trauma, Bismarck ND

Amy Eberle, BSN, RN
Trauma Coordinator
Sanford Medical Center, Bismarck ND

Abstract Body:

Objectives: While the impact of the oil boom has helped give North Dakota the lowest unemployment rate in the nation (3.2%), the ability to manage the increase in number of trauma cases has been challenging. According to the 2011 ND Trauma Data Report, North Dakota has 19 oil and gas producing counties. 14 Hospitals are located in those counties. From 2006 to 2011 the area has seen a volume increase of 129%. Most notably, between 2008 to 2011 the increase was 111%. One hospital had 12 patients recorded in the trauma registry in 2006, but an increase to 63 patients meeting trauma registry admission criteria in 2011. Only one Level II trauma center located in the oil producing county increasing volume at this hospital by 149% from 2006 to 2011. The rural hospitals have seen a 21% increase in patients transferred out to a Level II facility between 2010 and 2011. The object was to analyze trauma registry data over 5 years and to determine if the data demonstrated an increase in trauma and orthopaedic injuries and if the distribution was equal among males and females in similar age groups and equal in all regions of the state.

Materials and Methods: Data from the United States Census Bureau was used for information regarding population increases in the state of North Dakota from 2000-2011. Data from The North Dakota Trauma Registry from 2007-2011 was used to compare:
1. Total trauma injuries
2. Age groups (injured males plus females)
3. Sexual dimorphism (injured males compared to injured females by age groups)
4. Orthopaedic injuries (extremity and spine)
5. Trauma region

Trauma Submissions by Year

	TOTAL
2004	1432
2005	2034
2006	3597
2007	3715
2008	4031
2009	4638
2010	5331
2011	5695

Data obtained from the North
Dakota State Trauma Registry

Total Injured Males and Females by Age and Year

	2007	2008	2009	2010	2011
<1	23	24	35	37	43
1 to 4	53	81	96	103	95
5 to 9	68	113	106	133	121
10 to 14	139	166	173	210	202
15 to 19	415	419	461	547	537
20 to 24	390	389	470	575	596
25 to 34	472	480	636	723	843
35 to 44	457	489	529	573	600
45 to 54	460	552	569	680	772
55 to 64	364	383	508	556	567
65 to 74	266	268	324	369	332
75 to 84	340	357	416	423	488
85 plus	263	309	312	392	394
Total	3710	4030	4635	5321	5590

Total Injured Males by Age and Year

	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>
<1	15	13	21	19	27
1 to 4	32	56	49	65	59
5 to 9	36	69	62	85	76
10 to 14	87	109	119	148	128
15 to 19	283	252	294	345	352
20 to 24	288	272	330	391	452
25 to 34	346	349	439	538	642
35 to 44	336	334	358	400	451
45 to 54	329	382	380	475	547
55 to 64	215	257	326	370	365
65 to 74	142	128	174	215	171
75 to 84	144	148	161	181	193
85 plus	81	90	86	118	97
Total	2334	2459	2799	3350	3560

Data obtained from the North Dakota State Trauma Registry

Total Orthopedic Injuries Taken From AIS 2005

	<u>EXTREMITY SPINE</u>	
2007	4574	1050
2008	5453	1032
2009	5866	1328
2010	5741	1413
2011	6126	1574
Total	27760	6397

Abbreviated Injury Scale 2005

Total Injured Females by Age and Year

	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>
<1	8	11	14	18	16
1 to 4	21	25	47	38	36
5 to 9	32	44	44	48	45
10 to 14	52	57	54	62	74
15 to 19	132	167	167	202	185
20 to 24	102	117	140	184	144
25 to 34	126	131	197	185	201
35 to 44	121	155	171	173	149
45 to 54	131	170	189	205	225
55 to 64	149	126	182	186	202
65 to 74	124	140	150	154	161
75 to 84	196	209	255	242	295
85 plus	182	219	226	274	297
Total	1376	1571	1836	1971	2030

Data obtained from the North Dakota State Trauma Registry

Number of Patients Involving an Orthopedic Injury by Year

	<u>TOTAL</u>
2007	2590
2008	2768
2009	3174
2010	3286
2011	3217

Data obtained from the North Dakota State Trauma Registry

Yearly Trauma Submissions by Region

<u>YEAR</u>	<u>SE</u>	<u>NE</u>	<u>SW</u>	<u>NW</u>
2007	1365	500	1090	760
2008	1324	721	1254	726
2009	1400	828	1447	962
2010	1677	748	1624	1282
2011	1757	682	1673	1582

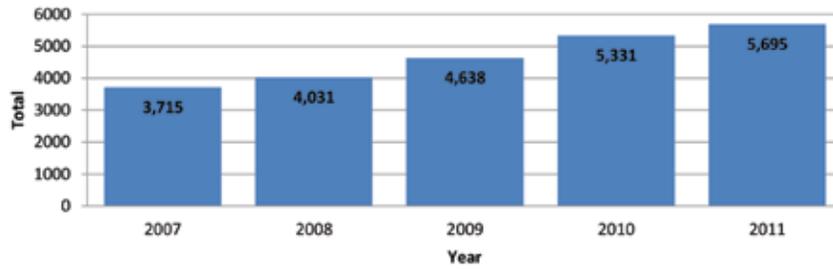
Data obtained from the North Dakota State Trauma Registry

Results: The North Dakota trauma registry recorded an increase in the number of trauma cases over the past five years as well as an increase in the volume of orthopaedic extremity and spine injuries. While all age groups of trauma have demonstrated an increase, most notably are those in the 25-34 and 45-54 year olds. Comparing males to females, the largest increase is: males 25-34 and 45-54 year olds. In females, the largest increase is seen in women 75 and above.

Orthopaedic injuries taken from AIS 2005 recoded a total of 5,624 to a volume of 7,700 in 2011.

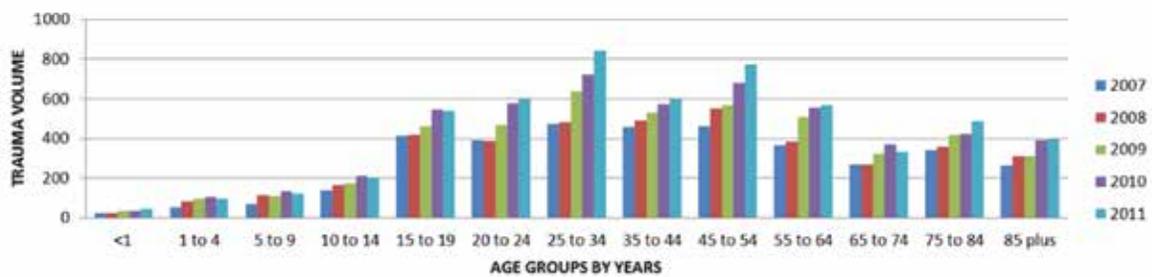
The largest increase in trauma cases are in the western regions. This region recorded 760 trauma cases in 2007 to 1,582 in 2011. This region supports the most activity in the oil boom.

Trauma Registry Submissions by Hospital Arrival Year



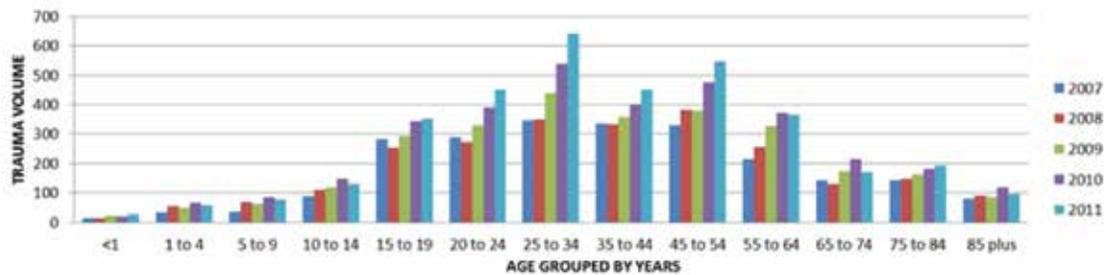
Data obtained from the North Dakota State Trauma Registry

INJURED MALES AND FEMALES BY AGE 2007-2011



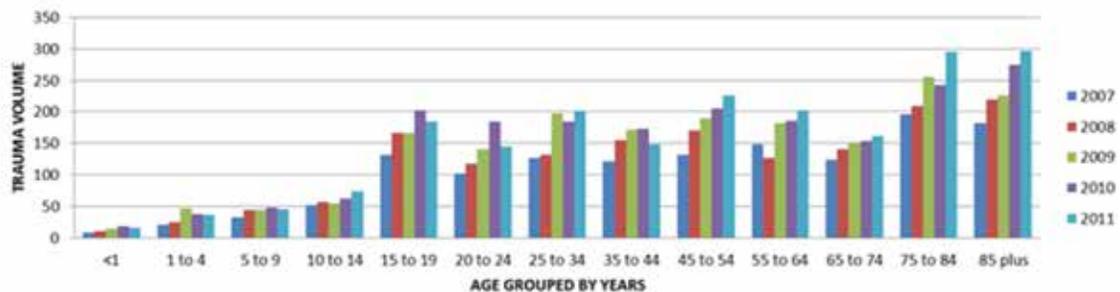
Data obtained from the North Dakota State Trauma Registry

INJURED MALES BY AGE 2007-2011



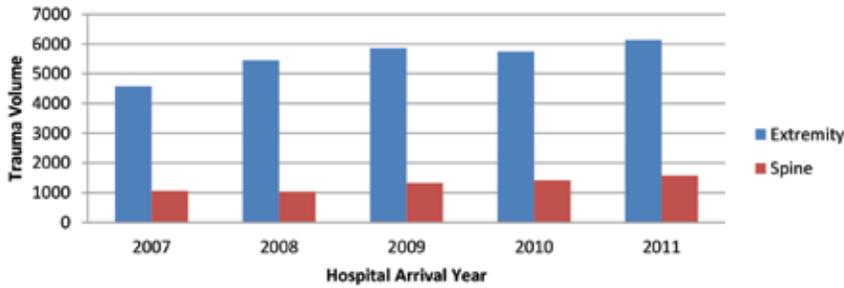
Data obtained from the North Dakota State Trauma Registry

INJURED FEMALES BY AGE RANGE 2007-2011



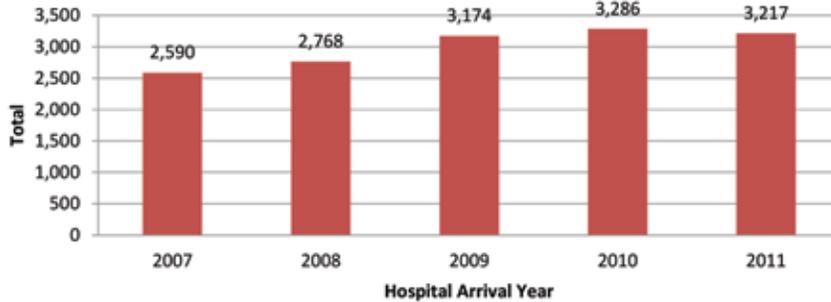
Data obtained from the North Dakota State Trauma Registry

Total Orthopedic Injuries Taken From AIS 2005



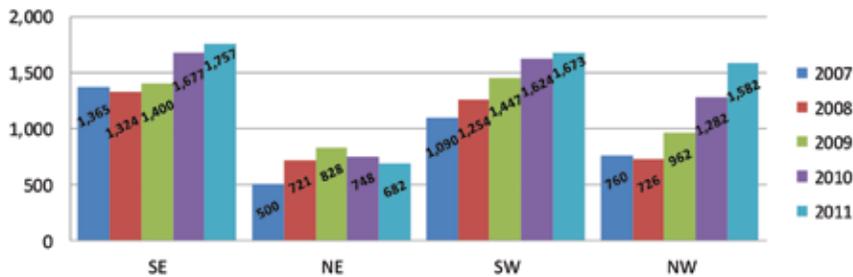
Data obtained from the North Dakota State Trauma Registry
Abbreviated Injury Scale 2005

Number of Patients Involving an Orthopedic Injury by Year



Data obtained from the North Dakota State Trauma Registry

Yearly Trauma Submissions by Trauma Region



Data obtained from the North Dakota State Trauma Registry

Conclusion: When compared with United State Census Bureau data, the overall rate of trauma and the number of orthopaedic injuries appears to be increasing. Males (25- 54 years old) appear to be injured more than females in this age group. Even though the rates of trauma in general appear to be increasing, the rate may be static in all age groups as the data is limited due to: 1) An increased population not accounted for by the census or census bureau estimates (transient); and, 2) Increased data submission compliance and reporting by hospitals over the past 5 years.

Further analysis within the Trauma Registry is needed to compare males and females with type, amount of trauma and orthopaedic injuries in each age group. This may determine if injury severity, including an increase in orthopaedic injuries, is correlated with regional trauma increases.

While North Dakota continues to have a bright economic future and continues to attract population due to economic factors and opportunity for jobs, further strategies to optimize trauma response and improve health care delivery is ongoing.

References:

North Dakota State Trauma Registry; North Dakota Department of Health, Division of EMS and Trauma Male Population by Single Year of Age for North Dakota: 2000 to 2010: U.S. Census Bureau - Census 2000; Population Division, Vintage 2009 Population Estimates, SC-EST2009-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2009; and Census 2010.

Male Population by Single Year of Age for North Dakota: 2010 to 2011: SC-EST2011-agesex-res: Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States and States: April 1, 2010 to July 1, 2011.

Female Population by Single Year of Age for North Dakota: 2000 to 2010: U.S. Census Bureau - Census 2000; Population Division, Vintage 2009 Population Estimates, SC-EST2009-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2000 to July 1, 2009; and 2010.

Population by Single Year of Age for North Dakota: 2000 to 2010: U.S. Census Bureau - Census 2000; Population Division, Vintage 2009 Population Estimates, SC-EST2009-AGESEX_RES: Annual Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: April 1, 2010 to July 1, 2011.

Population by Single Year of Age for North Dakota: 2010 to 2011: SC-EST2011-agesex-res: Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States and States: April 1, 2010 to July 1, 2011.

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North Dakota Medical Association
1622 E. Interstate Ave.
PO Box 1198
Bismarck, ND 58502-1198

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2014 Events Calendar

January 19-24, 2014

37th Annual Family Medicine Update:
Big Sky Conference 2014, Big Sky Resort,
Big Sky, MT.

For more information, contact Brandy
Jo Frei at 701-772-1730 or email
brandy@ndafp.org

March 15-16

North Central Medical Caucus
Conference, The Hilton - Minneapolis/
St. Paul Airport Mall of America
Bloomington, MN.

For more information, contact the
NDMA office at 701-223-9475

March 25, Noon

North Dakota Psychiatric Society
Conference Call.

For more information, contact the
NDPS office at 701-223-9475

April 25-26

North Dakota and South Dakota Chapter
of the American College of Surgeons
2014 Annual Meeting, Holiday Inn -
City Centre, Sioux Falls, SD.

For more information contact the ND
Chapter office at 701-223-9475

September 5-6

North Dakota Society of Obstetrics
and Gynecology Annual Meeting,
Ramkota Hotel, Bismarck, ND.

For more information, contact Dennis
Lutz, M.D. at 701-852-1555

October 2014

NDMA Annual Meeting,
Grand Forks, ND.

For more information, contact the
NDMA office at 701-223-9475