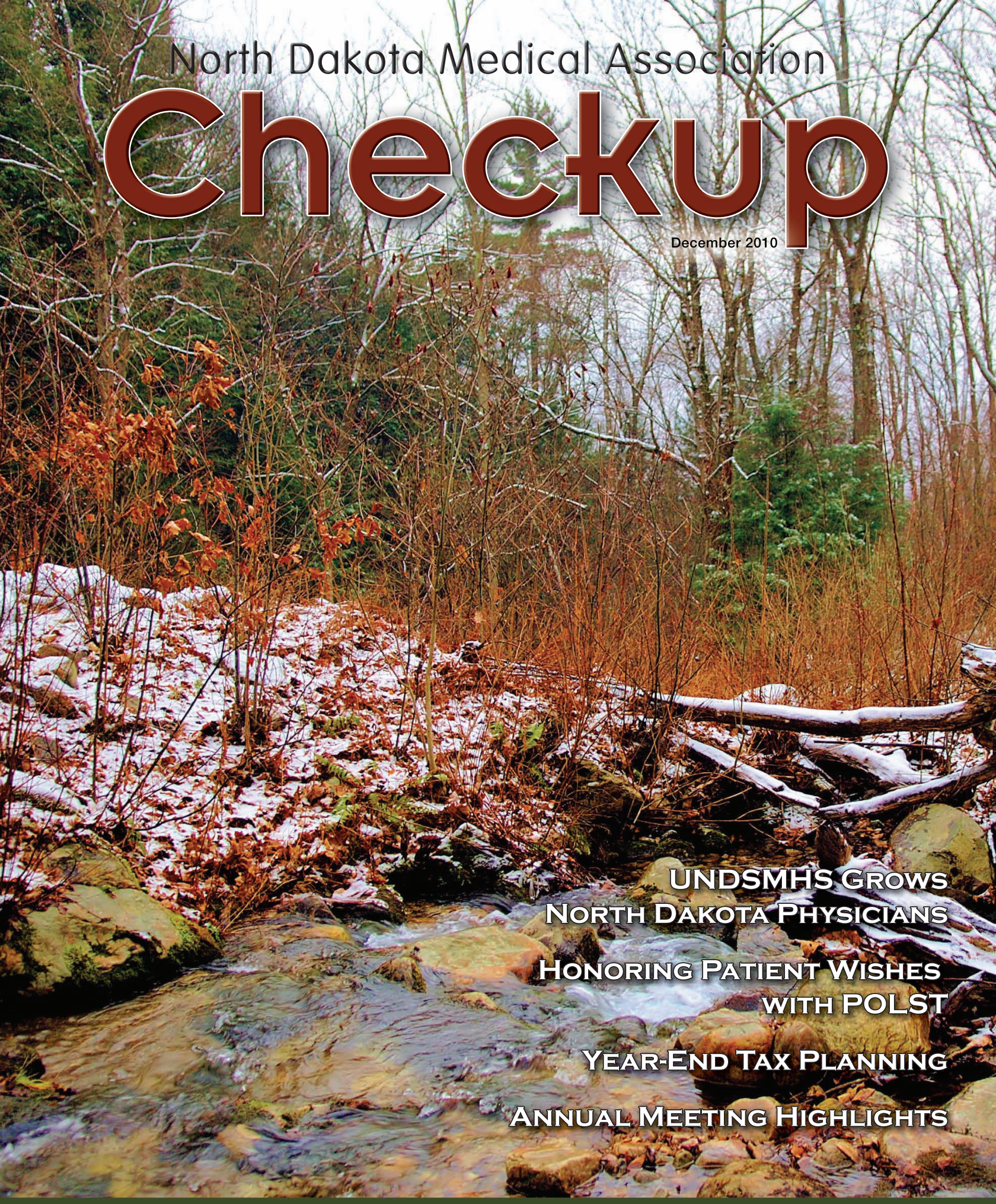
North Dakota Medical Association

Checkup

December 2010



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Cover: *Winter near Forest River, ND. Photo courtesy of North Dakota Tourism/David Nix*

North Dakota Medical Association

Checkup

The mission of the North Dakota Medical Association is to promote the health and well-being of the citizens of North Dakota and to provide leadership to the medical community.

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PRESIDENT'S *Message*

Kimberly Krohn, MD

The Digital Revolution in Medicine: Crafting the Positives and Protecting Against the Negatives–Leadership Needed!

I used to love change and learning new things. Hopefully I still do, even though I seem more grumpy about such things all the time. One of the many changes imposed on physicians as health care is "improved" is the ever increasing digitalization of information. When described that way, it seems like a really good thing with lots of obvious benefits. Of course medical information should be electronic–searchable, sortable, graphable, easily findable. It's the modern age. I used to compare our paper records of health care documentation with what happens at the grocery store, wondering how grocery stores could be decades ahead of us in digitalizing all of that information. Converting our patients' information from paper to electronic should make our jobs easier in a number of ways. It only makes sense.

Representative Earl Pomeroy stopped by my office within the last couple of months to chat. He, my partner Steve Stripe, MD, and I got to chatting about electronic health records. Representative Pomeroy was a wonderful student. He understood that we should be able to get data from electronic health records that is ungainly to extract from paper records. It should help us make better medical decisions, avoid duplicating tests, and provide chronic disease management and preventive services better and more efficiently. President Bush predicted in his 2004 State of the Union Address that a 20% reduction in health care costs per year could be realized by widespread adoption of the electronic medical record. That would be huge! Across our state, many hospitals and systems have invested heavily in technology to develop electronic medical record systems. According to Health Affairs, 11.9 percent of US hospitals in 2009 had adopted electronic health records. Our federal government has mandated that providers move down the road of not only adoption of electronic systems, but of "meaningful use" of them. The accreditation group for family medicine residencies has mandated EMRs in residencies. We know it's the right thing to do.

But Dr. Stripe and I focused on the negative with Representative Pomeroy. We've seen the "money pit" aspect of the systems currently available, requiring intensive customization of the products in order to achieve efficiency and effectiveness in practice. We've experienced the frustration of having to change the way we practice medicine in order to accommodate the EMR. Many of our colleagues who are really good at what they do have had really well established systems to make sure what they do is right and has good outcomes; they have had to change their systems to adapt to EMRs and thus new ways of functioning that are not their natural way of doing things. Picking up a textbook to look something up is considered old-fashioned by many–electronic resources are better. "Presentations" have now become "Power Points." This paper to electronic conversion doesn't respect our inborn preferences and talents. Our employers, patients, and colleagues expect us to obtain results just as great as before despite taking away many of the resources that we prefer and have learned to do well with. Representative Pomeroy was very humble–he said, roughly quoting, "Boy, we politicians look at it too simplistically." Of course, there aren't too many industries more complex than health care. There is some good data supporting the more negative reactions of physicians who struggle with the inefficiency of change, even if it's to using some really highly ranked EMR.

According to a study published in the Journal of the American Medical Informatics Association, EMRs increased physician documentation time by 17%, and computerized physician order entry increased physician documentation time by 98%! The American Journal of Medicine published an article showing that EMRs actually increase billings, disputing the cost savings prediction. The article casts doubt on whether the increased billing actually reflects increased care and improved outcomes, or just greater efficiency in capturing appropriate charges. Studies of the impact of EMRs on the quality of care are mixed–error reduction has not been widely reported, and

elimination of duplicate tests was not achieved in a two-year Kaiser Permanente study. Though EMRs should be associated with reduction in inpatient medication errors, one published report showed an increase in mortality in a NICU upon CPOE conversion because of delays, increased documentation time, and barriers to access to life-saving therapies. These studies may ring true with some physicians in our state as we reflect on our own EMR experiences. The reason I wanted Representative Pomeroy and others to hear the negative side of digitalizing health care information and communication processes is that they need to know how extremely difficult this process is and the many ripple effects that can occur along the way.

But there is hope. I encourage physicians to lead efforts to make EMRs better. I believe we should view them not as an end unto themselves, but as a means to transform and enhance our practices. And we should speak strongly against clinical systems that are developed that decrease physician efficiency. Typing and proofreading don't require a physician's education and experience. At some point health care systems that have adopted EMRs that require physicians to type and proofread will wonder why there is such a greater physician shortage than previously predicted. We also need to fix EMRs that suck the joy out of practicing medicine because they are just too difficult to use and/or don't allow us to use the many therapies that we know are important for our patients because they are too hard to order. We need lots of support from the "techies" to make sure these conversions and the constant upgrades required by existing systems don't jeopardize the quality and quantity of our work. We need to keep working towards having meaningful data for reflective practice as one of the outcomes of an EMR conversion. And finally, we need to acknowledge that this electronic conversion is really tough. It's disruptive to how we do things, so we need to work really hard to make sure it's worth it for our patients and our communities.

On a lighter note, some practical tips from my own life:

- my high school typing class was one of the best educational investments I have ever made
- looking over someone else's shoulder while they are using the same computer programs I use gives me some new technique to try almost every time
- a computer whiz who is readily available (thanks, Jennifer Wahl!) is essential for people like me who love their computers, but only when they work the way we think they should
- I try to acknowledge our IT people at our hospital for their great patience as often as I can because I really need them to keep being patient with me
- learning how to make Outlook folders for my email (thanks, Wade Talley!) has saved my life many times.

We are part of the digital revolution. We have no choice but to move forward in this process, and we can be present to make it a beneficial conversion for our practices and our patients. We need to have a tremendous amount of patience and the willingness to change how we do our work to achieve this. Fortunately, these are attributes that come naturally to many physicians. Acknowledging the challenges involved is an important part of a successful process.

Best of luck to all of you in practice in North Dakota.

'10 NDMA Annual Meeting *Highlights*

The 123rd Annual Meeting of the NDMA House of Delegates concluded its business Friday, September 10, electing officers and adopting resolutions including a resolution expressing physician views on the implementation of national health system reform. The resolution calls for NDMA to advocate for amendments and modifications to the federal *Patient Protection and Affordable Care Act* regarding those provisions that are inconsistent with NDMA policy and to assist physicians in evaluating opportunities to participate in demonstration programs and other opportunities under the health system reform law.

Other resolutions and business considered at the annual meeting include resolutions on physician orders for life-sustaining treatment (POLST) and graduated drivers licensing for teenagers, as well as discussion of a preliminary agenda for the 2011 ND Legislative Assembly. The NDMA Commission on Legislation, chaired by **Fadel Nammour** of Fargo, will continue working on NDMA priority issues for the session.

The House of Delegates also held annual officer elections. Reelected NDMA officers are **Kimberly T. Krohn** of Minot, President; **A. Michael Booth** of Bismarck, Vice President and Board Chair; **Steven P. Strinden** of Fargo, Secretary-Treasurer; and **Debra A. Geier** of Jamestown, Speaker of the House. **Gaylord J. Kavlie** of Bismarck was reelected to serve as NDMA's AMA Delegate and **Robert W. Beattie** was reelected to serve as our AMA Alternate Delegate.

At the annual awards dinner, **Robert R. Tight** of Fargo received the *NDMA Physician Community and Professional Services Award*. **Senator Byron Dorgan** will receive the *NDMA Friend of Medicine Award*.

In addition to the House business, congressional candidates **Rick Berg, Earl Pomeroy**, and **Tracy Potter** spoke on campaign issues and answered questions. New UNDSMHS **Dean Joshua Wynne** and UNDSMHS Advisory Council Chair **Dave Molmen** spoke at the NDMA luncheon on what's new at your medical school.

SAVE THE DATE!

The 2011 NDMA Annual Meeting will be held in Grand Forks on Thursday-Friday, September 22-23.

Suima Aryal, Suman Regmi, Esther and Olukayode Omotunde, Kim Krohn and Shari Orser at the NDMA social and dinner.

Dale Klein greets Rick Berg after Rick's address to the House of Delegates.

Ted Kleiman chats with Ricky Becker and Anne Claeson at the NDMA social and dinner.

Highlights

Steve and Cheryl Strinden, Ted Kleiman, Deb Geier, Linda Getz-Kleiman, and Jacob Goldenberg enjoy the social.

Robert Beattie greets Earl Pomeroy after Earl's address to the House of Delegates.

Dr. Tight Recognized for Community and Professional Service

Robert Tight, MD, received the NDMA 2010 Physician Community and Professional Services Award at the annual meeting banquet. The award recognizes outstanding members of the Association who serve as role models, active in both their profession and in their community.

Dr. Tight was recognized for his professional and community work spanning over 40 years in North Dakota, as recognized by Drs. Rup and Vani Nagala of Oakes who nominated Bob for the Award.

In presenting the Award, NDMA President Kim Krohn recognized Dr. Tight as "an excellent clinician and mentor. He has taught countless students and residents over the years and is one of our best teachers." In their letter of nomination, Rup and Vani Nagala expressed their appreciation for Bob's service over the past three decades as an infectious disease consultant for many physicians, particularly those in rural areas of the state. In Rup's and Vani's words, "Bob has been a tremendous resource not only in his field but as a mentor for many young students and residents. He has served in so many leadership positions and has helped both physicians and patients in the area of AIDS treatment. He has disseminated his knowledge, discipline and leadership in his field for the benefit of all of us who have been fortunate to work with him."

Debbie and Bob Tight with NDMA president Kim Krohn.

Bob has served as the ND Governor of the American College of Physicians, interim chair of the UNDSMHS Department of Medicine, and long-standing director of the ND AIDS Education and Training Center and chair and member of the North Dakota HIV/AIDS Advisory Council, as well as serving on numerous committees for both the medical school, MeritCare, the VA medical center and NDMA. In 1983 Bob served as a member of the People to People International Microbiology Delegation to the People's Republic of China. He

Dennis Wolf greets Tracy Potter after Tracy's address to the House of Delegates.

Tom Arnold (R) was recognized for his service as NDMA Councillor by Kim Krohn and Mike Booth.

served his country as an Army medical officer in Vietnam and Ethiopia from 1968 to 1971.

The NDMA tradition was also observed of honoring those physicians who have achieved at least 40 years of service to the medical community upon graduation from medical school (1970), with 17 physicians provided a Forty-Year Certificate of Appreciation, bestowing Life Membership in the Association. They are:

Bruce A Asleson MD, Fargo
Richard C Bailly MD, Fargo
Burton S Belknap MD, Fargo
James D Brosseau MD, Grand Forks
James E Call Jr MD, Minot
Dwight E Cramer MD, Fargo
Jayant S Damle MD, Grand Forks
William C Elder MD, Hettinger
David A Fitzgerald MD, Fargo
Jacob Kerbeshian MD, Erhard, MN
Ardashir Mardirosian MD, Jamestown
John T Martsolf MD, Grand Forks
Juan M Munoz MD, Fargo
Olukayode S Omotunde MD, Park River
Bapanaiah Penugonda MD, Grand Forks
Wallace E Radtke MD, Fargo
George S Stenger DO Ashley

Jack Kerbeshian was recognized by the ND Psychiatric Society during its annual meeting with the 2010 NDPS Mental Health Service Award. The award was created by the Society in 1999 to recognize and express appreciation to individuals or organizations for their outstanding advocacy efforts on behalf of mental health issues in their area or across the state.

Physicians Recognize Senator Dorgan as Friend of Medicine

Senator Byron Dorgan received the NDMA "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."

NDMA recognizes Sen. Dorgan for his work to improve health care for Native American people, for the many initiatives and projects that have improved our facilities and health delivery system, for his work recently to address Medicare payment disparity that impacts ND hospitals and physicians, and many other accomplishments.

Senator Dorgan was nominated by Tim Mahoney. The Friend of Medicine award is our way of recognizing those accomplishments and saying "thank you."

YEAR-END TAX PLANNING:

The Good Ole Days of 2010

Do you ever pine for the nostalgic days when life was simpler and there were no worries? Oh, if we could just go back. We not only survived but thrived without cell phones, smart phones, personal computers, internet, play stations, DVDs, or texting. Everyone was poor, and we were always outside playing or inside reading or actually interacting with each other, or moving the TV antenna hoping to receive a third channel. No one knew any better. Now we're not happy with only 99 channels and satellite radio to choose from.

But be careful what you wish for. You may think taxes to be high now, but believe it or not, taxes in 2010 are among the lowest in the last century, with the largest tax increase in American history to take effect on January 1, 2011 unless Congress intervenes to halt the Bush tax cuts which sunset December 31, 2010. Top marginal federal income tax rates in 1930 were 25%, 1940 81%, 1950 91%, 1960 91%, 1970 71%, 1980 70%, 1990 28%, 2000 39.6%, 2010 35%, 2011 39.6%, and in 2013 40.5%. You don't have to be a rocket scientist or brain surgeon to see a pattern here and predict future trends. With the country on the verge of bankruptcy, and ever-increasing federal spending, all political arguments aside, the numbers are simply unsustainable. It's simple math! And all this on the verge of implementing the largest entitlement program in the history of the country – national health care.

Doctors face certain reimbursement cuts and increased taxation as the country comes to terms with its whopping debt. With the United States teetering on the verge of bankruptcy, and a staggering national debt of nearly $14 trillion (and if you don't remember, that's 12 zeros, $14,000,000,000,000), there exists an ever-increasing and always unfulfilled demand for tax revenues. Our federal government is like a newborn baby; an insatiable appetite on one end, and no sense of responsibility on the other. Doctors will take a direct body blow.

It is not just the rich affected by the 2011 tax increases. The 10% bracket increases to 15%, the 28% to 31%, and the 33% to 36%. Do you realize your retirement plan is automatically diminished in value 3 to 4.6% January 1, 2011 when the top marginal rate increases 3 to 4.6 % for the two highest brackets (which is where most doctors fall)?

Furthermore, long term capital gains tax is currently 15%, and will increase to 20% in 2011, and 23.8% in 2012. Dividends are currently taxed at the long term capital gains rate of 15%, and in 2011 will increase to the top marginal rate, which is 39.6% - a 264% increase! Internal Revenue Code Section 529 plans for college saving, open to all taxpayers, regardless of income, will expire in 2011.

Other tax provisions expiring December 31, 2010 include:

1) The "marriage penalty," resulting from the fact that the standard deductions for married couples are less than double the single amounts, will return,
2) Phasing out of itemized deductions,
3) Phasing out of personal exemptions,
4) The child tax credit will be cut in half from $1,000 to $500 per child,

5) The dependent care credit is reduced from $3,000 to $2,400 of expenditures for one dependent, and from $6,000 to $4,800 for two or more dependents,

6) The increased AMT (alternative minimum tax) exemption expires, affecting thousands of doctors across the country,

7) For physician business owners, the $250,000 expensing of business equipment will be reduced to $25,000, and the 50% bonus depreciation will expire.

History will look with nostalgia to the good old days of 2010 when taxes were so low. 2010 was the year George Steinbrenner died with a $1.1 billion dollar estate and saved $600 million in estate taxes, and energy tycoon Dan Duncan of Texas died with a $9 billion estate and paid no estate taxes. However, the little guy profits too in 2010. It is not difficult for a doctor to accumulate a $2 million estate and be hit with confiscatory estate taxes, as the estate includes all assets, i.e., home, bank and stock accounts, retirement plans, and insurance payouts at death.

A doctor dying in 2010 with a $2 million estate pays no estate tax, but in 2003 would have paid $490,000 in estate tax ($1 million exemption and a 49% rate). In 2011 the estate tax comes back with a vengeance. That same doctor dying on January 1, 2011 will pay $550,000 estate tax ($1 million exemption, 55% rate). And remember, that is money the doctor has already paid over 50% tax on already during his or her working lifetime, if one includes federal, state, FICA, etc. in the calculus.

What is so special about 2010? The estate tax in 2010 has been repealed, and the last time there was no estate tax was in 1914 – 96 years ago! The current gift tax of 35% has not been this low since 1934. The top marginal income tax rate this year is a mere 35%. If history is any guide, doctors will be paying 50, 60, 70, and even 80% tax rates in the not too distant future. The government may not call it taxes, but rather license, registration or other various fees; surcharges, FICA, FUTA, Worker's Comp., assessments, duties, or uncapping Social Security income ceilings. Now that the elections are over, look for a VAT (value added tax) or national sales taxes. Look for tax credits to be phased out, charitable deductions reduced, etc.

There will be a day of reckoning for the unrestrained extravagance of the last decade, and in particular the last three years. "Rich" doctors will not get any breaks, and will disproportionately pay. It doesn't matter that we work 70-90 hours a week, holidays, evenings, weekends, and gave up our youth to pursue medicine. We can't bill for telephone time, get reimbursed for filling out insurance and Worker's Compensation forms, travel time to satellite clinics, charge for paper clips and copies, bill for our time thinking about a patient in the middle of the night or in the shower, or bill by the nanosecond and round up to the nearest hour. Do you think lawyers would tolerate such abuse for even 10 minutes? Medicine is the only profession where a neophyte out of residency, still wet behind the ears, gets paid the same as an experienced clinician with 20 years of practice under his/her belt. What is a doctor to do?

Advanced techniques in reducing or eliminating estate taxes are beyond the scope of this article, but suffice it to say that the estate tax is considered the "voluntary" tax among estate planning attorneys, and the overwhelming percentage of doctors who pay estate tax can completely eliminate it through judicious mainstream planning techniques that are conservative and safe and will withstand IRS or court challenges. If your attorney or advisor recommends an offshore account, run as fast as you can!

Is there anything a doctor can do now before year's end or beyond?

1) Plan your death in 2010 (just kidding). Beware of the hidden "estate tax" in 2010. There is no basis increase on assets passed on with some exceptions, which means potential significant capital gains tax liability for doctors dying in 2010.

2) Consider Roth conversion of qualified retirement plans. For the first time in 2010, individuals can convert funds in qualified plans or traditional IRAs to Roth IRAs, and are given the opportunity to include the converted income all in 2010, or split evenly between 2011 and 2012 (bad choice, as income tax rates will be higher then). This is a highly technical area to which an entire article can be devoted, but given the right conditions, huge income and even estate tax savings can be accomplished.

3) Increase income in 2010 before December 31.

4) Push expenses into 2011 when tax rates are higher, and more tax can be saved.

5) Pay as much capital gains as possible in 2010 when rates (long term gains) are only 15%. Combine this with a Roth conversion by selling equities from funds outside the retirement plan with a low basis to pay the income taxes and you win big, by paying lower capital gain and income taxes.

6) Harvest capital losses up to $3,000 by matching with capital gains. Harvest capital gains against any capital loss carryovers.

7) Contribute to 529 plans for college education. One can prefund the plan with 5 years of contributions gift tax free.

8) Postpone charitable contributions until 2011.

9) If you own a clinic, delay equipment purchases until 2011 or take depreciation rather than expensing in 2010. You need to consider whether it's more advantageous to take a full deduction in 2010 or to spread the deduction out over future years with higher tax rates.

10) For Health Savings Accounts, purchase non-prescription drugs in 2010, as they are not eligible for reimbursement after December 31, 2010.

11) Pay for energy efficient improvements to your home in 2010, as the residential energy credit up to $1500 expires December 31, 2010.

12) Take advantage of the Opportunity Tax Credit which is available for the first four years of higher education. This expires December 31, 2010.

There is a high likelihood that Congress will tinker with the tax laws over the next several months. It remains to be seen whether Congress will act during the lame duck session after the wave election or wait until the newly elected senators and representatives are sworn in January. Remember, if Congress does nothing (does that ever happen?) by year's end, the Bush tax cuts will sunset December 31, 2010. This article may well be out of date by the time it is published, so consult with your professional advisor.

Physicians face ethical issues as well as financial issues as 2010 closes. This current tax uncertainty and cataclysmic change set to occur midnight December 31, 2010 has the potential to generate some interesting colloquies in the ICU at 11:45pm on December 31, when one is considering withdrawing life support. Do we withdraw support before or after midnight? It may mean the difference between the heirs receiving nothing versus several hundred thousand dollars inheritance, or whether the family farm can be passed on. I can envision stat consults for the estate planning attorney in the ICU for the unfortunate patient on the throes of death but expected to die before midnight or survive beyond midnight. Radically different legal language is required to plan for transfer of assets, depending if death is before or after midnight. I can envision oral or holographic (written in one's own hand) wills created just in the nick of time. What a legal morass. Should a request by the agent for the durable power of attorney for health care be honored if ulterior motives are suspected? The author is not suggesting this should even be a factor in the discussion, but human nature being what it is, undoubtedly such situations will arise somewhere in the country. And to think I'm covering neurosurgery call over New Year's! Oh, I'm getting a headache. May the sun never set December 31, 2010!

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Prepare Now for the ICD-10 Transition

The change to ICD-10 codes takes effect on October 1, 2013. What do you need to get ready?

Providers will need to use ICD-10 diagnosis and inpatient procedure codes starting on October 1, 2013. And in preparation for ICD-10, starting January 1, 2012, all practice management and other applicable software programs should feature the updated Version 5010 HIPAA transaction standards.

Make sure your claims continue to get paid. Talk with your software vendor, clearinghouse, or billing service NOW, and work together to make sure you'll have what you need to be ready. A successful transition to ICD-10 will be vital to transforming our nation's health care system.

Visit www.cms.gov/ICD10 to find out how CMS can help prepare you for a smooth transition to Version 5010 and ICD-10.

CMS CENTERS for MEDICARE & MEDICAID SERVICES ICD-10

Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

NDMA House Adopts Resolution on POLST

The NDMA House of Delegates adopted a resolution expressing NDMA policy to urge North Dakota physicians and other health care professionals across all health care settings consider Physician Orders Life-Sustaining Treatment (POLST) components in developing initiatives across the state.

POLST is designed to improve the quality of care people receive at the end of life across all care settings and is based on effective communication of patient wishes, documentation of medical orders on a form, and a commitment by health care professionals to honor these wishes to ensure that a seriously ill person's wishes regarding life-sustaining treatments are known, communicated, and honored across all health care settings. While advance directives are created by patients to communicate their wishes about health care decisions and may be difficult to interpret, POLST forms are used by a physician to document and communicate a person's wishes to other health care professionals and are often used as a tool to help physicians discuss treatment options with patients already diagnosed with serious illnesses.

NDMA's Commission on Ethics, chaired by Rolf Paulson, MD of Grand Forks, has discussed POLST and Altru Health System has incorporated POLST components in a form used to help health care professionals honor the treatment desires of their patients across various care settings beyond the use of current advance directives. There are considerable indications of interest in POLST across the state by health systems and others.

A recent National Institutes of Health-supported study published in the Journal of the American Geriatrics Society suggests that the POLST program offers significant advantages over traditional methods to communicate preferences about life-sustaining treatments, i.e., that residents with POLST forms are more likely to have treatment preferences documented as medical orders than those who did not and that POLST orders restricting medical interventions are associated with less use of life-sustaining treatments [*A Comparison of Methods to Communicate Treatment Preferences in Nursing Facilities: Traditional Practices Versus the Physician Orders for Life-Sustaining Treatment Program*, The Journal of the American Geriatrics Society, July 2010; 58:1241-1248].

The Minnesota Medical Association's Committee on Ethics and Medical-Legal Affairs recently endorsed a POLST form created by an interdisciplinary workgroup in that state which was acceptable to hospitals, nursing homes and physicians in that state [Vawter L, Ratner E, The Need for POLST: *Minnesota's Initiative*, Minnesota Medicine, January 2010].

The resolution adopted by the House of Delegates places the NDMA Commission on Ethics as a focal point for continued discussions about making POLST available as a tool for North Dakota physicians and healthcare facilities, including consideration of whether a standardized POLST form could be used throughout the state.

Physician Orders for Life-Sustaining Treatment (POLST) in Altru Health System and Surrounding Facilities

Nancy Joyner, RN, MS, APRN-CNS, ACHPN
Clinical Nurse Specialist-Palliative Care
Altru Health System - Altru Hospital

In June 2007, Altru Health System initially developed a workgroup including physicians, nurses, social workers, chaplains and other disciplines to study and plan for implementation of the Physician Orders for Life-Sustaining Treatment (POLST) form. The POLST form is a document/physician's order designed to help healthcare providers honor the treatment wishes of patients. It is designed to express the individual's preferences for: levels of treatment such as full treatment including resuscitation attempts or can be used to limit those interventions that are not desired by the individual.

The POLST orders (www.polst.org):

- Promote patient autonomy
- Enhance authorized transfer orders between facilities
- Clarify treatment intentions and minimizes confusion regarding preferences
- Reduce repetitive activities in complying with the Patient Self-Determination Act
- Facilitate appropriate treatment by emergency medical services personnel
- Enhance the quality of a person's care
- Complement the healthcare directive
- Go beyond the healthcare directive by turning those wishes concerning life-sustaining treatments into specific, medical orders which can be understood and be followed by the medical team
- Are filled out and signed after learning the patient's wishes about emergency care and end-of-life care the patient wants or does not want
- Become a physician's order and is kept in the medical record under physician's orders

Altru's physician champions on POLST have been Wayne Breitwieser, MD and Keith Swanson, MD. The POLST was implemented August, 2007 and augmented replacement of standing Code levels of 1, 2 and 3, to the designations of Full Code, DNR, DNR/DNI or Comfort Measures Only, which is used throughout the United States. The POLST form was used when individuals chose DNR, DNR/DNI or Comfort Measures Only for resuscitation choice and then there was discussion on the level of treatment. The signed copy accompanies the patient when they are discharged or sent to another facility. Many of the local and regional nursing homes also implemented the POLST form. The North Dakota Palliative Care Summit in 2008 also discussed POLST as a document that could be utilized within and across treatment settings as well.

Altru Health System worked with first responders and paramedics with hopes of implementing POLST in the surrounding Grand Forks community. The education part of that process is still being implemented.

In January 2010, Altru Hospital discontinued using the POLST form routinely within the acute setting due to the time it took to complete them, unclear prognosis in some cases and the frequent change of the treatment plan. However, the code level designations remained as Full Code, DNR, DNR/DNI and Comfort Measures Only. The POLST form is still sent with patients on transfer to another facility, and used in specific situations such as guardianship, family request for clarification from the patient and other circumstances.

For Whom Should POLST Be Used?

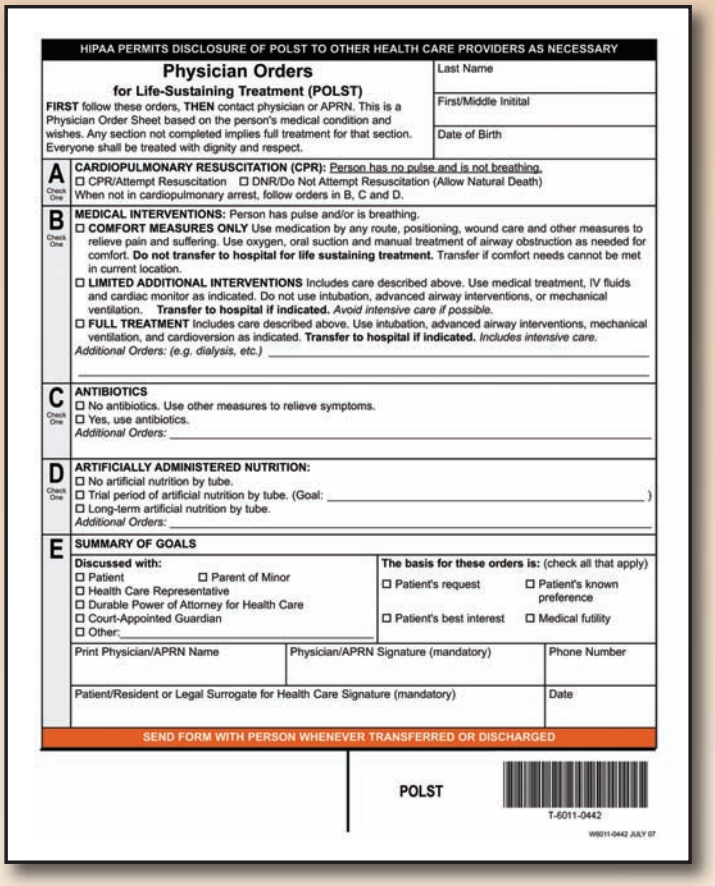
Use of the POLST form is most appropriate for seriously ill persons with life-limiting conditions or terminal illnesses. To determine whether a POLST form should be encouraged, clinicians should ask themselves, "Would I be surprised if this person died in the next year?" If the answer is "No, I would not be surprised," then a POLST form is appropriate. Unless it is the patient's preference, use of the POLST form to limit treatment *is not appropriate for persons with stable medical or functionally disabling problems who have many years of life expectancy.* In the absence of a POLST form or other specific do-not-resuscitate orders, patients will receive advanced cardiac life support, including CPR, endotracheal intubation, and defibrillation, by emergency medical personnel based on

standard protocol. The form is an order and can be followed by first responders.

Growth of the POLST Paradigm in Bordering States

In 2008, the Montana Board of Medical Examiners took the lead for developing, promoting and using the POLST form in their state. In 2009, the Minnesota Medical Association (MMA) hosted an interdisciplinary task force to develop the standardized POLST form that is now endorsed by both the MMA and the Emergency Medical Services Regulatory Board.

Currently, the NDMA Ethics Commission is discussing future directions for the POLST for North Dakota. As the state POLST coordinator, I am hoping to establish POLST as a recognized and used order in North Dakota. The goal is to have a form that can move with the patient, from home to medical settings and to a variety of agencies.



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

Physician Orders for Life-Sustaining Treatment (POLST)

FIRST follow these orders, **THEN** contact physician or APRN. This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name | First/Middle Initial | Date of Birth

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** Person has no pulse and is not breathing.
☐ CPR/Attempt Resuscitation ☐ DNR/Do Not Attempt Resuscitation (Allow Natural Death)
When not in cardiopulmonary arrest, follow orders in B, C and D.

B Check One — **MEDICAL INTERVENTIONS:** Person has pulse and/or is breathing.
☐ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital for life sustaining treatment.** Transfer if comfort needs cannot be met in current location.
☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. **Transfer to hospital if indicated.** *Avoid intensive care if possible.*
☐ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. **Transfer to hospital if indicated.** *Includes intensive care.*
Additional Orders: (e.g. dialysis, etc.) _____

C Check One — **ANTIBIOTICS**
☐ No antibiotics. Use other measures to relieve symptoms.
☐ Yes, use antibiotics.
Additional Orders: _____

D Check One — **ARTIFICIALLY ADMINISTERED NUTRITION:**
☐ No artificial nutrition by tube.
☐ Trial period of artificial nutrition by tube. (Goal: _____)
☐ Long-term artificial nutrition by tube.
Additional Orders: _____

E **SUMMARY OF GOALS**

Discussed with:
☐ Patient ☐ Parent of Minor
☐ Health Care Representative
☐ Durable Power of Attorney for Health Care
☐ Court-Appointed Guardian
☐ Other: _____

The basis for these orders is: (check all that apply)
☐ Patient's request ☐ Patient's known preference
☐ Patient's best interest ☐ Medical futility

Print Physician/APRN Name | Physician/APRN Signature (mandatory) | Phone Number

Patient/Resident or Legal Surrogate for Health Care Signature (mandatory) | Date

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

POLST

T-6011-0442

W6011-0442 JULY 07

Comparison of Advance Directives & Physician Orders for Life-Sustaining Treatment (POLST)

DETAILS	ADVANCE DIRECTIVE	POLST
For whom?	For all adults over 18	For any age person with advanced or serious/ critical illness
Why have one?	• For directing end of life care via a legal document • To express values • To appoint a Proxy/ Agent/ Surrogate	Medical orders which turn a patient's values into action
Can it guide actions by Emergency Medical Personnel?	No	Yes
Can it guide treatment decisions in the hospital?	Yes	Yes
Are the person's wishes known?	Yes	Maybe
When does it go into effect?	When the person cannot speak for themselves, usually at the end of life, with certain stipulations on their needs and conditions	Applies to the present for code level/CPR, treatment options, best interest and levels of care, across all settings, including intensive care and emergency rooms
Who makes the decision?	Patient, Proxy/ Agent, hopefully based on the person's written document and/or best interest	Patient, unless unresponsive, then Proxy/ Agent/ Decision Maker
Where is it completed?	Anywhere, sometimes law office	With the physician, in their office, the hospital, or a care facility
Who signs it?	Patient, witnesses, attorney or notary and sometimes	
Proxy/ Agent	Physician, patient and or Proxy/ Agent/Decision Maker	
How long can it last?	Usually a permanent record, but can be updated- should be reviewed periodically	Can change from day to day or remain in place indefinitely; reviewed when the person's condition changes, moved to a different setting, or person requests a change
Where is it kept?	Usually with legal papers (safety deposit box, attorney's office, safe, etc.) and sometimes in the medical record- copies should be with the person, Proxy/ Agent, (attorney if used) and in the medical record.	In the person's medical record, and given to the person, at home- kept on the fridge or designated area for Emergency Medical Personnel

Greetings from the University of North Dakota School of Medicine and Health Sciences

Dr. Jon Allen directs ND STAR (Simulation, Teaching and Research for Health Education), where students gain clinical experience in a safe and controlled environment.

Joshua Wynne, M.D., M.B.A., M.P.H.
Vice President for Health Affairs, Dean
Professor of Medicine, University of North Dakota School of Medicine and Health Sciences

I bring you greetings from the faculty members, staff, and especially the students of your School of Medicine and Health Sciences. As one of only 25 community-based medical schools in the country, we rely on you and your colleagues to help teach clinical medicine to our medical and health science students. We simply don't have enough full-time clinical faculty members–or a university hospital–to do otherwise. Thus, it is with profound thanks and appreciation that I am pleased to bring this update to the membership of the North Dakota Medical Association. By the way, both my wife (Dr. Susan Farkas, a cardiologist) and I are proud members of the NDMA. I am honored to acknowledge the more than 900 voluntary faculty members throughout the state who have clinical appointments at the UND School of Medicine and Health Sciences (SMHS), which is an impressive majority of the roughly 1500 practicing physicians in the state.

I am now in my sixth month as vice president for health affairs at UND and dean of the SMHS. As the calendar year comes to a close, I am proud of the accomplishments of the School this past year, and indeed, over its 105-year history. Permit me to review some of the notable recent accomplishments of the men and women of the School and outline some of our plans for the future. The School's accomplishments can be grouped into four categories: processes, people, programs, and places.

PROCESSES

While interim dean (and especially as dean), I've worked hard to develop a culture at the School that encourages dialogue, communication, listening, and shared governance. We've taken a number of concrete steps to encourage the

embrace of these values, the first of which is the column that I write in our weekly electronic newsletter, called *E-News*. In the course of the last two years, I've written nearly 100 columns on a wide variety of health care-related issues that affect the School and our state. The columns seem to have been well received, although I can tell you for a fact that not everyone always agrees with my comments! But the columns have served to keep the School's stakeholders informed and involved, and have stimulated two-way discussions. While many of the members of the NDMA receive this electronic publication, we don't have the e-mail addresses of all of our voluntary clinical faculty members. Accordingly, the NDMA has kindly agreed to e-mail our weekly *E-News* to its membership beginning soon; should you wish to opt out of receiving *E-News*, the NDMA will indicate how you can do so, but we hope that you'll appreciate this brief update on the activities of the SMHS. If you would like to review any or all of the prior columns as well as the current column, please visit my webpage *www.med.und.edu/dean/*.

I've also participated in a variety of forums to visit with physicians from around the state. To date, I've held meetings with the medical staffs at half of the larger hospitals in the state; we're in the process of setting up visits to the remaining hospitals. I've also visited some of the smaller communities and facilities such as in Devils Lake and Oakes. In addition, I've held several faculty town hall meetings that have been transmitted to all of the campus offices and were available online. Video recordings of these meetings are also available on the Web at *www.med.und.edu/dean/*.

PEOPLE

Recently, we've been fortunate enough to recruit several truly outstanding faculty members to the School. These new members of our team will help take the SMHS, in the words of UND President Robert O. Kelley, "from great to exceptional." First of all, I would note Dr. Gwen Halaas, who was recruited from the University of Minnesota a little over a year ago. In acknowledgement of her outstanding contributions in the short time that she has been with us, I recently promoted her to the position of senior associate dean for Academic and Faculty Affairs. As such, Gwen coordinates our educational enterprise, while also overseeing our academic and faculty development portfolio. A family medicine physician who hails from the Fargo–Moorhead area, Dr. Halaas brings a wealth of experience, insight, and perspective to the Office of the Dean.

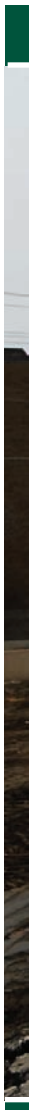
To assist Dr. Halaas in the Office of Academic and Faculty Affairs, we recently added additional responsibilities to three longtime and highly regarded SMHS faculty members following a formal internal search process. To coordinate preclinical medical school education, Dr. Tom Hill, director of the Office of Medical Education, has been appointed assistant dean. To oversee the varied educational activities involving undergraduate and graduate students, Dr. Ken Ruit has been appointed assistant dean for Undergraduate and Graduate Education, in addition to his ongoing duties as vice chair of the Department of Anatomy and Cell Biology. And to oversee the vital area of faculty development (including helping voluntary clinical faculty such as many of you with their educational activities), we appointed Dr. Pat Carr as assistant dean for Faculty Development.

Rounding out our administrative team is Dr. L. Gary Hart, recently recruited to direct our esteemed Center for Rural Health. An expert in rural health care workforce needs and development, Gary is already hard at work along with the nearly 50 dedicated advocates for rural medicine employed at the Center.

PROGRAMS

I'm very pleased to report that we achieved a milestone recently, when the State Board of Higher Education approved a graduate level program in public health. The need for better education within the state regarding public health policy and procedures is obvious, especially in this era of terrorist threats and worry about environmental influences on health. Considerable interest within the state in providing a course leading to the Master in Public Health (M.P.H.) degree has come from State Health Officer Dr. Terry Dwelle, various physicians, county public health officials, hospital and clinic administrators, and students. Two features of our proposed program are noteworthy: First, the degree program (and the associated certificate program) will be a truly joint–and integrated–effort of the two research-intensive universities in the state, North Dakota State University and the University of North Dakota. Second, much of the program will be taught online, thus making it more convenient for prospective students from across the state, many of whom likely would find it difficult to travel multiple times to Fargo or Grand Forks or both.

Our basic and clinical research programs also are excelling. In a time of very tight federal funding, the faculty members of the SMHS have managed to increase the funding of sponsored programs by 48 percent to the second-highest total in the history of the school–some $22.7 million! Most of these dollars are federal in origin, and most go to salaries of co-investigators and laboratory personnel, creating employment opportunities in the state that would not exist otherwise. In fact, the SMHS is an eco-



nomic engine, generating about a dollar in new revenue from sponsored programs for every appropriated dollar derived from the state. Overall, the School produces $2.61 from all sources for every general fund dollar provided by the state. But the research enterprise of the SMHS obviously is more than just an economic engine for the state; the research also translates into improving the quality of life of North Dakotans.

The last new program I'd like to review is our RuralMed program. Funded last legislative session, this program is intended to remove some of the financial barriers that may steer medical students away from a primary care career in a rural region of North Dakota. The program offers a full tuition waiver for all four years of medical school for up to eight students per year who agree to practice family medicine in a rural area of North Dakota for five years. The value to a prospective student exceeds $100,000, a major fraction of the debt of over $150,000 that the average medical student acquires in the course of her studies. Although the program has required some refinements, we're excited about the program and believe that it will help to alleviate the shortage of rural primary care providers in North Dakota.

PLACES

We're very excited about two brand-new facilities, one just opened and one under construction. The simulation laboratory in Grand Forks just opened, and it offers a fantastic variety of human simulators. Dubbed North Dakota STAR (Simulation, Teaching, and Research for Health Education), the Sim Lab can simulate everything from birth to a cardiac arrest by utilizing lifelike manikins. The facility, which is adjacent and attached to our Clinical Education Center in Grand Forks, features four simulation rooms and associated debriefing and instructional classroom space. Intended for a wide variety of learners, the Sim Lab is open not only to medical students but also nurses, paramedics, physician assistants, practicing physicians, and other health care workers.

We recently broke ground for the construction of a new Center for Family Medicine clinic building in Bismarck. The 45,000-square-foot, three-story building is a coopera-

Left to right: UND President Robert O. Kelley, NDUS Chancellor Bill Goetz, UND SMHS Dean Joshua Wynne, Bismarck Mayor John Warford, Medcenter One CEO Dr. Craig Lambrecht, ND Rep. RaeAnn Kelsch, St. Alexius CEO Andy Wilson, Sen. Conrad representative Tim Moore.

tive effort involving Medcenter One, St. Alexius Medical Center, and UND. The facility will be located between Medcenter One and St. Alexius Medical Center, thus convenient to both institutions and their patients, faculty members, staff, and students. The new location offers improved parking and easier access for clinic patients. It also features 20 exam rooms, four procedure rooms, X-ray and laboratory space, and business and administrative offices. For patients' convenience, the facility will also include a pharmacy. Scheduled to open in a year, the building will fulfill two major needs: a modern, up-to-date facility in which the School's Bismarck family medicine residency can see its patients, but also an educational facility that will help train medical and health science students, along with family medicine residents, who will benefit the entire state. In addition, the educational space within the building will be open to the general public and patients, and will focus on health prevention, health maintenance, and wellness promotion.

HOW ARE WE DOING?

So just how well is the SMHS doing in its core mission of helping to educate and provide the requisite health care workforce for the citizens of North Dakota? Based on analyses by several external organizations, I'd say "pretty well." While there clearly is more that we can and should do, here are some measures of our success:

- Your School has ranked number one in the nation on the last two surveys conducted by the American Academy of Family Physicians (AAFP) as to the percentage of the senior class specializing in family medicine
- North Dakota ranks number three in the nation in the percentage of its graduates practicing in a rural location, according to the Robert Graham Center of the AAFP.
- We also rank number seven in the nation in the percentage of our graduates who enter primary care, again according to the Robert Graham Center of the AAFP.
- The SMHS ranks number five of all U.S. allopathic medical schools in the percentage of physicians practicing in a rural area after graduating from medical school from 1988 to 1997, according to a study published in the journal *Academic Medicine* (Chen et al., 2010, Acad. Med., 85, p. 572).

THE FUTURE

North Dakota (as well as the rest of the country) likely will face a doctor and other health care worker shortage

of about 30 percent by 2025. The physician shortage alone for North Dakota likely will exceed 210 doctors by 2025. This shortage will be affected by the disproportionate burden of elderly patients in North Dakota; for example, we are second only to Florida in the percentage of our population over the age of 85. The School of Medicine and Health Sciences, in conjunction with the SMHS Advisory Council, has developed a plan to meet that workforce need through a combination of retaining more of our own graduates as well as widening the pipeline by expanding class size. The plan has been vetted and endorsed by a unanimous vote of the State Board of Higher Education, and is now pending review by the Governor's office and the Legislature.

Our plan, called GOOD for North Dakota (Growing Our Own Doctors), calls for the following to allow us to retain more and train more of our own:

- Increasing the medical school class size by 16 students a year (a 29 percent increase)
- Increasing the health sciences class size by 30 students a year, or 15 percent
- Increasing residencies (post-medical school training) by 17 residents a year
- Establishing a Master of Public Health degree in conjunction with North Dakota State University
- Developing a geriatrics training program
- Continuing our RuralMed program to encourage students to specialize in family medicine and practice in rural areas of North Dakota, along with multiple other measures to enhance retention of our own graduates in North Dakota
- Constructing a new building in which to house the roughly 200 new students, faculty members, and staff once the program is fully implemented

If approved, the plan would have a significant positive economic impact throughout the state. We estimate that almost two-thirds of the economic impact of the fully implemented workforce plan will be outside of Grand Forks. The SMHS would generate about $2 of new revenue (often federal grant and contract money) for every dollar of appropriated state funds invested.

I am extremely proud of what your School has achieved in the past, and what we are poised to achieve in the future. With your help and support, we can continue to serve the people of North Dakota and help provide them with the very best in health care, through education, service, and research. We can't do it without you, but with your continued help, we can take the School from great to exceptional!

Thank you again for all that you do. Susan and I extend our very best wishes for a wonderful holiday season, and a healthy and happy new year!

NDMA Briefings

By Bruce Levi, Executive Director

It's Back to Work

The 2010 election campaign is over; the 2011 ND Legislative Assembly and 112th Congress are poised to begin.

At the national level, this was a watershed election in terms of physician candidates, with more than 80 physicians running as challengers or in open seats for federal office at one point during the cycle. The Republican majority in the U.S. House added six new physicians to its ranks. Newcomers include Larry Bucshon, MD (R-IN) a cardiothoracic surgeon; Andy Harris, MD (R-MD) an anesthesiologist; Dan Benishek, MD (R-MI) a general surgeon; Joe Heck, DO (R-NV) an emergency physician; Nan Hayworth, MD (R-NY) an ophthalmologist; and Scott Desjarlais, MD (R-TN) a family medicine physician. The Senate also added one physician, Rand Paul, MD (R-KY), an ophthalmologist.

Kilzer

In North Dakota, Bismarck orthopedic surgeon Ralph Kilzer of District 47 was reelected to his third term in the ND Senate, now having served in six legislative sessions since winning election to the ND House in 1996. Spencer Berry, a family medicine physician from District 27 in Fargo was elected for his first term in the ND Senate.

Berry

2011 ND Legislative Assembly Organizes for Health Policy Work

The 2011 ND Legislative Assembly convenes January 4. The executive budget which will impact physicians through Medicaid, the UND School of Medicine & Health Sciences and other ways will be unveiled by our new Governor Jack Dalrymple during the organizational session in early December. As in every session, NDMA will advocate to improve and protect the physician practice environment, the patient-physician relationship, and support initiatives to improve the health of the public.

The UND School of Medicine & Health Sciences and ND State Board of Higher Education are seeking legislative support for a health care workforce plan to meet ND workforce needs through a combination of retaining more of our own graduates, as well as widening the pipeline by expanding class size. The plan, called GOOD for North Dakota (Growing Our Own Doctors), would increase the medical school class size by 16 students a year (a 29 percent increase), increase residencies (post-medical school training) by 17 residents a year, and construct a new building in which to house the roughly 200 new students, faculty members and staff once the program is fully implemented.

A number of other initiatives will be introduced this session. ND Insurance Commissioner Adam Hamm is introducing several bills designed to begin the process of implementing requirements imposed on states as part of national health system reform. These include bills requiring the Commissioner to plan and implement a health benefit exchange for North Dakota, revising statutes relating to preexisting conditions and benefit limits, and other issues arising from the federal health reform law.

Over time, many important implementation responsibilities will fall on states under the *Patient Protection and Affordability Care Act of 2010* (PPACA) including:

- Overseeing health insurance market reforms
- Establishing and running health insurance exchanges
- Running medical liability reform demonstration projects
- Implementing numerous public health initiatives
- Serving as demonstration sites for delivery system reform initiatives
- Implementing the Medicaid expansion

- Expanding program integrity activities
- Helping to implement federal health information technology standards and administrative simplifications

Medicaid also faces challenges with a substantial reduction in the federal match (FMAP) due to the state's favorable economic climate compared to the rest of the country. The 2009 Legislative Assembly adopted a statement of legislative intent that the Department of Human Services establish a goal to set Medicaid payments to 100% of cost for hospitals, physicians, chiropractors and ambulances, and progress toward that goal may be reflected in an optional adjustment request in the Department's budget.

Interim committees of the ND Legislative Management have concluded their work. Bills introduced as part of the recommendations of interim committees of the ND Legislative Council include workers compensation bills setting protocols for pain therapy and payment for prescription drugs, changes in the state's mental health commitment laws, health information technology confidentiality and exchange, authority for pharmacists to give flu shots and immunizations to children, and others.

Scope of practice issues will likely be prevalent with nurse practitioners asking to remove the requirement of a collaborative agreement with a physician for prescriptive authority and licensed addiction counselors wanting to perform mental evaluations in court-ordered mental health commitment proceedings. More of these "scope" issues will likely come to the legislature, and NDMA will analyze and advocate on each issue separately to the degree each proposal impacts the safety of patients and the quality of medical care.

Lame Duck Congress Faces 25% Medicare SGR Cuts

In a letter to U.S. Congressional leaders, NDMA joined 116 other physician groups in urging Congress to take action to "permanently replace the Sustainable Growth Rate (SGR) formula with a system that keeps pace with the cost of caring for our nation's seniors." Recognizing the unlikelihood of a permanent fix in the upcoming lame duck session, the groups are calling on Congress to pass a statutory payment update "that lasts at least through the end of 2011" to provide time for Congress and the physician community to develop "a long term solution to ensure that seniors can count on finding physicians to care for them, and that physicians will not view Medicare and TRICARE as threats to the viability of their practice. Earlier this year, the *Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010* stabilized Medicare physician payments, but only until November 30, 2010. After that, Medicare payments for physician services will be slashed December 1 by more than 23 percent and by another 2% on January 1.

According to AMA, the cuts would result in $40 million less in payments to North Dakota through the end of 2011.

Prospects for a 13-month SGR fix are not clear, according to some reports, although some kind of "doc fix" is likely to emerge in the lame duck session.

While the Frontier States amendment in the health reform law will make inroads to the unfair Medicare payments to ND hospitals and physicians, the work on geographic disparity continues. The Institute of Medicine (IOM) launched a study on Medicare's geographic adjusters in September. A leader for our Geographic Equity in Medicare (GEM) Coalition, Michael Kitchell, MD, of Ames, Iowa, testified regarding fallacies in GPCI inputs and weights, resulting in Medicare payment disparities that fail to reflect physician practice costs. Dr. Kitchell emphasized that the GPCIs were meant to assure "equal pay for equal work" by adjusting for actual physician practice cost differences but that the GPCIs, relying upon irrelevant proxies and inaccurate weights, have failed to do that. Nationwide surveys of physician practice costs show that physicians in rural states experience among the highest practice costs yet rural Part B payment localities have among the lowest geographic adjustment factors (GAFs).

HHS Secretary Kathleen Sebelius commissioned the IOM study. A fifteen member committee is directed to evaluate the validity and accuracy of both the GPCIs and the hospital wage index, their measures and methodologies, and their data sources and the degree to which such data is representative of Medicare providers' costs. The IOM committee emphasizes that its study will be empirical and comprehensive. It will issue two reports, the first in May of 2011 focused on the adjustment factors themselves and the second in May of 2012 focused on the effect of the adjustment factors on providers' ability to furnish efficient, high value care. Prior to issuance, each IOM report will be subject to extensive peer review.

Secretary Sebelius anticipates implementing IOM study findings as part of the CY 2013 physician payment rule. She further intends coordination of IOM study findings with the results of CMS' study of the practice expense (PE) GPCI currently underway and initially reported in CMS' proposed CY 2011 physician payment rule. Language passed as part of the PPACA directs the CMS study and grants payment relief to those localities with PE

GPCIs of less than 1.0 for CY 2010 and 2011 while the CMS study is underway.

Looking Forward

The medical community here and across the country is moving through a period of great turbulence – no question about it. Physicians can turn to their own leadership in NDMA to provide them with guidance and leadership through these challenging times.

NDMA is working to improve the physician practice environment, strengthen medical education including the UND School of Medicine & Health Sciences and our residency programs, strengthen our ability to recruit and retain a quality healthcare workforce, facilitate health information technology, improve the health of the public, and improve our ability to continue to provide some of the highest quality, safest and cost-efficient medical care in the country.

Effective organizations welcome the risks associated with action. NDMA has not sat on the sidelines – and not avoided risk. It has been a time of working within difficult processes to ensure that physician voices are heard.

NDMA confronted a major challenge in the Congress with health system reform and Medicare payment reform, advocating in a principled manner consistent with NDMA policy and mission. Recently, the NDMA House of Delegates adopted a resolution calling for additional advocacy to address provisions of concern in the *Patient Protection and Affordable Care Act* and to assist physicians in evaluating opportunities to participate in demonstration programs and other opportunities under the health system reform law. And of course, we are not done in fighting off proposed cuts in Medicare payments. For almost a decade, the sustainable growth rate formula has triggered a pay cut we fight each year to postpone. We continue to work for a permanent SGR fix.

In sum, we have experienced results that will benefit physicians and their patients in North Dakota. At the same time, considerable challenges await us, particularly in the implementation of health system reform and the 2011 ND legislative session.

In this time of unprecedented change, you need to support and use the physician leadership and structure of the NDMA to develop positive solutions to solve the problems you face in your practice. **NDMA can be a strong leader on behalf of you and your patients.**

AMA House Addresses Implications of Health System Reform, Looming SGR Cuts, Private Contracting and More

Report of the NDMA Delegate to the AMA House of Delegates
Gaylord Kavlie, MD

The AMA House of Delegates convened November 6-9, addressing policies on modifying the health care reform law, devising a permanent fix to the Medicare payment formula under the Sustainable Growth Rate (SGR), and addressing the implications of new health care delivery models such as Accountable Care Organizations (ACOs) and private contracting.

Alternate Delegate Robert Beattie along with NDMA President Kim Krohn and Vice President Mike Booth participated with me in the interim meeting and worked with our regional caucus, the North Central Medical Conference (ND, SD, IA, MN, NE, WI).

The AMA House of Delegates includes physicians from every state and specialty who gather to set policy that shapes the actions of the AMA on a wide range of issues of importance to physicians and their patients across the country.

More SGR Cuts to Stop

The AMA House began its Interim Meeting with a call on Congress to address the immediate and long-term problems of Medicare physician payment.

AMA President Cecil B. Wilson, MD, said in an opening-session speech that the Association will work with the new Congress to stabilize Medicare pay for physicians through at least 2011 and seek other payment solutions.

The AMA and other medical organizations are seeking a 13-month patch because they don't expect the lame-duck session, which started Nov. 15, to approve a permanent solution to the sustainable growth rate formula that determines physicians' Medicare payments. Physician pay is set to go down 23% on Dec. 1 and an additional 2% on Jan. 1, 2011, if Congress does not act.

AMA Leadership Changing

The backdrop for the interim meeting included an announcement by AMA Board of Trustees and AMA Executive Vice President and Chief Executive Officer (CEO) Michael Maves, MD, MBA, that Dr. Maves will complete his leadership of the AMA when his current contract ends on June 30, 2011. Dr. Maves has served in this role since 2001.

During his tenure, Dr. Maves personally led important multi-association efforts such as the "Scope of Practice Partnership," a coalition of national medical specialty organizations and state medical societies established by

the AMA to clarify the roles and capabilities of non-physician health care providers. The AMA's House of Delegates also took a number of positions related to various aspects of health system reform. Working under the direction of the Board of Trustees, Dr. Maves led the management team in carrying out those directives.

From an organization standpoint, Delegates referred a proposal calling for an ad hoc committee to study transforming the AMA into an "organization of organizations." The change would shift the AMA from an association of individual, voluntary members to an umbrella group for state and specialty societies.

The idea had been raised in previous years, and proponents said the issue deserves another look because of declining AMA membership.

Here's a recap of many of the actions taken by the House.

New Ethics Guidance on Social Media Use and More

Several reports from the AMA Council on Ethical and Judicial Affairs (CEJA) were adopted by the House, providing ethical guidance to physicians regarding 1) disclosure of health status to children and adolescents; 2) physicians' responsibility to engage patients in advance care planning; 3) physicians' obligations to be vaccinated as professionals committed to promoting the welfare of individual patients, health of the public, as well as safeguarding their own and their colleagues' well-being; 4) nonsimultaneous, altruistic organ donation; and 5) online social networking.

Delegates adopted policy that says physicians should routinely discuss advance care planning with patients, regardless of age or health status. Physicians should be prepared to answer patients' questions and encourage them to discuss their plans with loved ones.

Breaking new ground in addressing social media, Delegates urged caution. Social media is increasingly being used as a communication tool by physicians, both in their personal lives and practices. When using Twitter, Facebook and other social media, physicians should be cognizant that their communications are widely available and could have professional repercussions, according to policy adopted by delegates. Physicians also should be aware of patient privacy laws and not do anything to jeopardize patient privacy.

The CEJA report acknowledged that social networking resources, blogs and other forms of online communication create "new challenges" in the patient-physician relationship, and it advised physicians to weigh a number of considerations when maintaining an online presence.

- Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.
- When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content.
- If physicians interact with patients on the Internet, they must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines.
- To maintain appropriate professional boundaries, physicians should consider separating personal and professional content online.
- When physicians see content posted by colleagues that appears unprofessional, they have a responsibility to bring that content to the attention of the individual so he or she can remove it or take other appropriate actions. If the behavior violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.
- Physicians must recognize that actions online and posted content may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers – particularly for physicians-in-training and medical students – and can undermine public trust in the medical profession.

Delivery Reforms: Accountable Care Organizations, Private Contracting

The House of Delegates adopted a series of principles regarding the establishment and operation of accountable care organizations (ACO), one of the new payment and delivery models established under the federal *Patient Protection and Affordable Care Act*. There were several resolutions that elicited testimony reflecting a general anxiety about the rapidly changing environment of payment and delivery reforms, including bundled care payments and legal structures for clinical integration.

The new AMA principles, developed to provide direction for federal regulations being created, state that the goals of an ACO are to increase access to care, improve the quality of care and ensure the efficient delivery of care. ACOs must be physician-led and encourage collaboration, the new guidelines say. Medical decisions should put patients' interests first without conflict with commer-

cial concerns. Participation by physicians and patients should be voluntary.

Delegates asked the AMA to clarify its support of anti-trust relief for physician-led ACOs, which it previously stated in a letter to the Federal Trade Commission and other agencies.

On the health insurance mandate, the AMA referred for further study whether to advocate for significant penalties for not having health insurance or tax incentives. Several Delegates stated that the recent elections indicated that the public opposes health insurance mandates. Others said mandates were necessary to support aspects of health system reform, including an end to rescission of insurance coverage for any reason other than fraud.

On private contracting, the AMA will pursue a grassroots campaign to adopt the *Medicare Patient Empowerment Act*, a proposal that would allow patients to contract privately with physicians while retaining access to Medicare coverage.

Private contracting would allow physicians to set fees and charge patients more than standard Medicare rates. Physicians would have the option of not collecting a co-payment from patients who can't afford one. Under policy adopted by delegates, the AMA will report back on the measure's progress at its Annual Meeting in June 2011.

CMS on Never Events, PECOS and Signature Requirements

The House adopted a report that examines ways to minimize the impact of CMS' hospital acquired conditions-present on admission rule (HAC-POA), and recommends ways to further strengthen AMA advocacy efforts in this area.

A Minnesota resolution was adopted for AMA to urge CMS to re-evaluate the Medicare requirement that physicians sign all notes, and orders, such as re-occurring physical therapy and lab work.

The AMA will ask CMS to address problems that physicians have had enrolling in Medicare's online registration system, the Provider Enrollment, Chain and Ownership System, or PECOS. The Association also will seek an extension of the Jan. 3, 2011, enrollment deadline.

Medical Staff Self-Governance

The House adopted a resolution to call upon The Joint Commission to clarify in its *Accreditation Manual for Hospital Medical Staff Chapter* description of medical staff self-governance to state that the medical staff selects and removes its officers, with no authority permitted in medical staff bylaws for the governing body to approve, disapprove, revoke, or otherwise influence or act on the medical staff's election of its leaders, and to communicate this clarification as a priority.

Public Health Policy Focuses on Sports Concussions, Immunization of Health Workers

The House weighed in on public health issues by extending support for universal influenza vaccination of health care workers to include seasonal and H1N1 influenza. It also urged that marijuana's status as a federal Schedule I controlled substance be reviewed to facilitate clinical research and development of cannabinoid-based medicines.

In addition, the House supported a requirement that athletes participating in school or youth sports who are suspected of having a concussion should not return to play or practice without a physician's written approval. They also asked the AMA to support legislation requiring the use of helmets by youths 17 and younger while skiing or snowboarding.

Delegates also voted in support of a resolution calling for universal immunization of health care workers against seasonal and pandemic influenza. Also approved was a report recommendation calling for universal immunization of physicians against vaccine-preventable diseases.

Appropriate Roles of Physicians and Non-Physicians

The House asked the AMA Board to provide further clarity regarding non-physicians who may be performing invasive procedures, including the use of fluoroscopy, interventional pain management procedures and other treatments. Delegates also adopted new policy that, in academic environments, the AMA only support payment models for non-physician practitioners that do not interfere with graduate medical training.

The Work Goes On

As I noted in our last issue of *Checkup*, the work goes on and the AMA will continue to play a critical role in steering all of medicine through difficult policy debates. AMA and our other physician organizations are still at the table, and will continue to press for what's best for you and your patients in the next Congress and beyond.

New Offices Oversee Health Reform Implementation: What and Who You Need to Know

Source: AMA Health System Reform *Insight*

Entities within the Obama administration responsible for employing two fundamental aspects of the Affordable Care Act (ACA)–private health insurance reform and innovative delivery and payment reforms in Medicare and Medicaid–are working at a rapid pace on implementation activities and drafting regulations.

The Department of Health and Human Services (HHS) has created several new offices and significantly increased its staff in order to execute provisions enacted in the ACA. Information about relevant HHS regulations and health system reform implementation efforts can be found on HHS's new *HealthCare.gov* website. The Centers for Medicare & Medicaid Services (CMS) has also undergone realignment to more readily advance the Medicare and Medicaid delivery reforms being piloted and tested as required by the ACA.

The following is a brief overview describing some of the new key offices and personnel within HHS and CMS that are charged with implementing reforms of the private insurance market and pilot testing new payment and delivery models.

HHS Office of Consumer Information and Insurance Oversight

The HHS Office of Consumer Information and Insurance Oversight (OCIIO) is tasked with implementing all private insurance reforms enacted in the ACA. Jay Angoff, a former insurance commissioner in Missouri and consumer legal expert, is Director of the OCCIO.

According to HHS, the "office is responsible for ensuring compliance with the new insurance market rules, such as the prohibitions on rescissions and on pre-existing condition exclusions for children that take effect this year. It will oversee the new medical-loss ratio rules and will assist states in reviewing insurance rates. It will provide guidance and oversight for the state-based insurance exchanges. It will also administer the temporary high-risk pool program and the early retiree reinsurance program, and compile and maintain data for an internet portal providing information on insurance options."

Joel Ario, a former insurance commissioner in Pennsylvania, was appointed on August 30 to serve as Director of the Office of Insurance Exchanges within the OCIIO. Ario will oversee the implementation of the state-based health insurance exchanges, which are required to be operational in 2014.

HHS Office of Delivery System Reform

The HHS Office of Delivery System Reform will oversee HHS efforts to promote new proposed payment and delivery reforms, such as accountable

care organizations (ACOs), bundling and the medical home. While these pilots and demonstrations will be directly implemented by CMS, the Secretary has wide discretion on many key aspects of these reforms. Peter Lee, former president and CEO of the Pacific Business Group on Health, is the new Director of this office.

CMS Center for Medicare and Medicaid Innovation

The CMS Center for Medicare and Medicaid Innovation (CMMI) was established by the ACA to test innovative payment and service delivery models that reduce program expenditures and preserve or enhance the quality of care. In choosing models to study, the Center is charged with giving preference to those that improve coordination, quality and efficiency of health care services to Medicare and Medicaid beneficiaries.

The CMMI is housed within CMS. A Director for the CMMI has yet to be named, so it is currently being overseen by Anthony "Tony" Rodgers, Deputy Administrator for Strategic Planning at CMS.

The CMMI is expected soon to announce its plans for providing technical assistance directly to physicians–specifically those in smaller practices–to help them participate in ACOs. This effort is separate from and in addition to the ACO/shared savings pilot program authorized in the ACA.

CMS Center for Medicare

In March, CMS announced an organizational realignment that includes the creation of a new Center for Medicare. This Center combines the operations of the Medicare fee-for-service program, Medicare managed care and the Medicare prescription drug benefit. It is directed by CMS Deputy Administrator Jonathon Blum.

The Center for Medicare is responsible for the CMS proposed rulemaking on the shared savings/ACO pilot that will begin in 2012. It is anticipated that a draft regulation setting forth the parameters of this pilot will be released late this fall.

CMS Center for Strategic Planning

CMS created its Center for Strategic Planning, directed by Deputy Administrator Tony Rodgers. The Center oversees the Office of Research, Development, and Information (ORDI), which is responsible for CMS demonstration projects such as the ongoing acute care episode bundling demonstration and the physician group practice demonstration. ORDI will oversee new payment and delivery demonstration projects authorized by the ACA, such as bundling and the medical home.

Patient-Centered Outcomes Research Institute

The U.S. Government Accountability Office (GAO) on September 23 announced the appointment of 19 members to the Board of Governors of the new Patient-Centered Outcomes Research Institute (PCORI). Also established by the Affordable Care Act (ACA), the PCORI is being set up as an independent, nonprofit organization and not a federal office to fund research projects on the comparative effectiveness of various patient diagnostic, treatment and disease prevention methods.

Twelve physicians are among the first 19 appointments, with experience spanning from large group practices and academic medicine to patient organizations, the U.S. Department of Veterans Affairs and the pharmaceutical and medical device industries. The director of the Agency for Healthcare Research and Quality and the director of the National Institutes of Health, or their designees, will also serve on the PCORI Board.

The purpose of comparative effectiveness research is to enhance physician clinical decision-making and foster the delivery of patient-centered care. Most current research on medical treatments compares the benefits of a specific treatment to no treatment, but little information is available to physicians to help them determine if new treatments outperform existing options.

During the congressional debate, concerns were raised that the new PCORI could evolve into a rationing agency akin to the National Institute for Health and Clinical Excellence, which produces clinical guidelines for care provided by the National Health Service in England and Wales–based largely on evaluations of efficacy and cost effectiveness.

Under the terms of the ACA, however, the PCORI is prohibited from issuing mandates or recommendations concerning practice guidelines, coverage recommendations or policy, and is charged with using rigorous evidence standards and methodologies. Further, the law specifically forbids the new institute from factoring cost into its clinical evaluations.

EMR/HIT Assistance Available for North Dakota Providers

In February 2010, the Key Health Alliance of Minnesota was named as the federally-designated Health Information Technology Regional Extension Center (REC) for North Dakota and Minnesota. The MN-ND Regional Extension Center, known as REACH, is one of 60 HIT Regional Extension Centers in the country. The REC program, managed by the Office of the National Coordinator, was implemented to help ensure that priority physician practices, clinics, or small rural hospitals can achieve Stage 1 meaningful use of an electronic health record system and receive the maximum amount of Medicare/Medicaid incentives for meaningful use in the first year.

Key Health Alliance is a partnership of three Minnesota-based organizations–Stratis Health, the QIO for Minnesota, the Rural Health Resource Center, and the College of St. Scholastica. The Alliance works collaboratively with North Dakota Health Care Review and the UND Center for Rural Health to operate the REACH program in North Dakota, and the NDMA is a member of the North Dakota REACH Advisory Council.

REACH assistance is designed to move providers and hospitals from their current state–whether no EHR is in place or their current system needs optimization–to Stage 1 meaningful use in 12 months or less. Services include:

- Readiness assessments–determining where the organization is on the continuum of readiness to adopt an EHR and providing a plan to prepare the organization for the EHR adoption process
- Practice and workflow redesign–planning and preparing for the cultural changes, as well as clinical, and business benefits of EHR
- Assistance in selecting a certified EHR product that offers the best value for the organization's needs–helping the provider understand and develop system requirements and needs through identifying the vendor that best meets those needs
- Vendor contracting–providing sample contracts and opportunities to connect with preferred vendors for an accelerated contracting process
- Process for EHR project management–offering a process to work with the selected vendor to ensure effective implementation of a certified EHR product
- EHR optimization and meaningful use–leveraging an EHR's potential to improve quality and value of care by enhancing clinical and administrative workflows, process improvement, template building, and clinical decision support alignment
- Technical reporting–such as Crystal Report writing, SQL programming, or other technical services to support attestation and quality data submission to CMS
- Privacy and security best practices–providing training on how to comply with legal requirements to protect patient health information, including breach notification, risk mitigation, policy and procedure templates, and business associate management
- Functional interoperability and HIE assessment and guidance–from the basics of e-prescribing to preparing the organization to participate in health information exchange with other provider organizations and with other entities such as the immunization registry, public health and for quality reporting.

Services provided by the REACH program are subsidized for the first two years of the program, with a 10% match required of participating providers. The North Dakota legislature has allocated match dollars for North Dakota organizations that utilize REACH services. Providers that utilize REACH services and attain meaningful use milestones are eligible for reimbursement of the match amount until June 30, 2011. Additional funds for reimbursement of the match amount are contingent on ND legislative appropriation for the next biennium and REACH funding from ONC. The three meaningful use milestones are:

- Milestone 1 – Service Level Agreement for REACH services
- Milestone 2 – e-Prescribing/CPOE and Quality Data reporting on a certified EHR
- Milestone 3 – Meaningful Use

Current match reimbursement amounts are:

- Critical Access Hospital (CAH) - $444 for each Milestone achieved up to $1333 total
- Participating Primary Care Provider (PPCP) - $183 for each Milestone achieved up to total fees paid

Registration for REACH services is available at: *http://khareach.org/ehrs/register*. For more information contact Tina Kessel, REACH HIT Regional Coordinator/ HIT Consultant, at North Dakota Health Care Review (701)852-4231 or tkessel@ndhcri.org.

AMA Alliance

North Dakota Medical Association Alliance

Mary Shuman
Director, AMA Alliance

We were stationed in Alaska. Lili and I had returned home after a grueling three months stay at Seattle Children's Hospital. I was invited to a neighborhood wives' meeting. The evening was to conclude with a cookie exchange. There was no way I could bake cookies. Our kitchen cupboards were stocked with Lili's medical supplies and the refrigerator was filled with bags of hyper-alimentation feedings. Ross optimistically remarked, "After what you've been through they'll want to give you all of the cookies."

Reluctantly I went. I arrived empty-handed and I returned home empty-handed. On the way out someone said, "Too bad you didn't bring any cookies."

The cookie incident left me with a bitter taste. I had better ways to occupy my time.

Fast forward 13 years. In 1997 the Buchanan County Medical Alliance invited me to a *Welcome Coffee*. Reluctantly I went. I arrived empty-handed and I returned home with a basket filled with goodies. I was hooked.

Physician spouses understand the unique demands placed upon medical families. The Alliance is our exclusive go-to group for support. The Alliance is dedicated to serving as the volunteer voice for healthy families everywhere.

Lili's illness and death was my inspiration as Missouri State Medical Association Alliance President. My theme was: "Each of us is but one personal tragedy away from becoming politically active."

On the national level I have served two years as a legislation committee member and two years as the chairman. I am delighted to be assigned as AMA Alliance Director to North Dakota.

We live in Saint Joseph–one mile from I-29. It was a door-to-door drive to Fargo for the 2010 NDMA and NDMA Alliance Annual Meeting. Guest speaker Tom Sullivan's heartwarming presentation was inspirational. I enjoyed lunch with fellow Alliance members. Everyone at the table is an enthusiastic, dedicated community volunteer. Mr. Sullivan sums up the collective spirit perfectly, "If extraordinary people can do impossible things, isn't it reasonable to assume that ordinary people can do extraordinary things." Thank you for your warm hospitality.

My earliest memories are of life on the farm in North Dakota. We lived near Killdeer. My brothers, sisters, and I would play for hours, jumping from the barn loft into stacks of hay. We helped churn butter, gather eggs, pump water, and pick countless wild flowers from the meadow out back.

We still have the farm. My Dad's fondest wish had been to return to North Dakota. Dad never made it back. But I did.

Mary Shuman
AMAA Director

North Central Alliance Regional Leadership Conference

FRIDAY, MARCH 4-6, 2011

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Minneapolis, MN 55402
612-338-2288

Make your plans now to join Alliance leaders from your neighboring states at the North Central Conference in Minneapolis, MN. North Central includes Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota & Wisconsin. Registration forms will be available in December. Please contact Dinah Goldenberg 701-298-8779 or dinahgold@cableone.net for more information.

MMIC | Midwest Medical Insurance Company

By Cinda Velasco RN, JD, Attorney-Risk Management

MMIC Malpractice Claim Review

Specialty:
Surgery

Allegation:
Improper performance of colonoscopy resulting in perforation

Risk Management and Patient Safety Focus:
Documentation

A 54-year-old male with a family history of colon cancer went to his surgeon for a colonoscopy. During the procedure, the surgeon removed four polyps.

The following day, the patient came into the emergency department complaining of severe pain in the right lower quadrant of his abdomen. His white blood count was elevated to 12,200 with a left shift. The surgeon ordered an upright abdominal X-ray, but did not see any free air under the diaphragm. The surgeon then ordered a CT scan, which showed a localized perforation in the area of the right lower quadrant near the cecum. The surgeon's differential diagnosis was either colonic perforation secondary to colonoscopy or possible appendicitis. That afternoon the patient went into surgery and the surgeon repaired a large perforation at the junction of the hepatic flexure and ascending colon in a retroperitoneal position.

The patient had an uneventful recovery and was discharged a few days later. The patient filed a malpractice claim against the surgeon claiming the perforation was negligent care.

Disposition of Case:
The case closed with no payment to the patient.

Risk Management and Patient Safety Perspective:

The medical experts who reviewed this case agreed that colon perforation is a recognized risk of colonoscopy occurring in approximately 1 in 1,000 procedures. The reviewers agreed that the surgeon recognized the complication in a timely manner and appropriately took the patient to surgery for repair of the perforation. The surgeon documented in the medical record a good informed consent discussion with the patient, including discussion about the risk of perforation. In addition, the nursing staff documented that the patient watched an educational video and was given written information about colonoscopy.

Risk Management Tips:

The actual discussion between the physician and the patient is the critical element when obtaining informed consent. Thorough documentation of the informed consent discussion is important to provide essential evidence when defending a claim alleging negligent nondisclosure.

MMIC recommends that physicians document the informed consent discussion in the progress notes if the patient is hospitalized, or in the chart notes if the discussion takes place in the physician's clinic. A signed consent form provides additional evidence that the discussion occurred.

Most consent forms and patient education materials are written at a 10th grade or higher reading level. The average American reads at an 8th to 9th grade level and one out of five adults reads at or below a 5th grade level. Therefore, the readability of your consent form and patient education materials should be at a 5th to 8th grade level.

Revise consent forms and patient education materials so that they are easy for your patients to read and understand:

- Provide only the essential information in order of importance
- Use plain, simple non-medical words
- Use short paragraphs
- Categorize information by using bullets
- Use large font
- Use simple graphics
- Enhance the use of "white space"
- Translate forms and education materials into the language of your patients

Always document any educational materials given to the patient as part of the informed consent process. Keep copies of all educational materials accessible in the facility, noting the date when any updates or changes are made to the materials.

Always document any educational materials given to the patient as part of the informed consent process. Keep copies of all educational materials accessible in the facility, noting the date when any updates or changes are made to the materials.

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2011 Calendar of Upcoming Events

January 17-21	Family Medicine Update / Big Sky Conference, Big Sky, Montana. For more information contact Brandy Jo Frei at 701-772-1730 or email brandy@ndafp.org
March 19-20	North Central Medical Caucus Conference, Minneapolis, MN
April 7-9	North Dakota Academy of Family Physicians Annual Meeting, Minot. For more information contact Brandy Jo Frei at 701-772-1730 or email brandy@ndafp.org
April 8-9	ND-SD Chapters of the ACS Annual Meeting, Radisson Hotel, Fargo. For more information contact the NDMA office.
September 9-10	ND Society of Obstetrics and Gynecology Annual Meeting, Ramkota Inn, Bismarck. For more information contact Dennis Lutz at 701-852-1555
September 22-23	NDMA Annual Meeting, Grand Forks, Alerus Center NDMA Alliance Annual Meeting, Grand Forks, Alerus Center