ND Physician

FALL 2018

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ND Physician

NDMA NORTH DAKOTA MEDICAL ASSOCIATION

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

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

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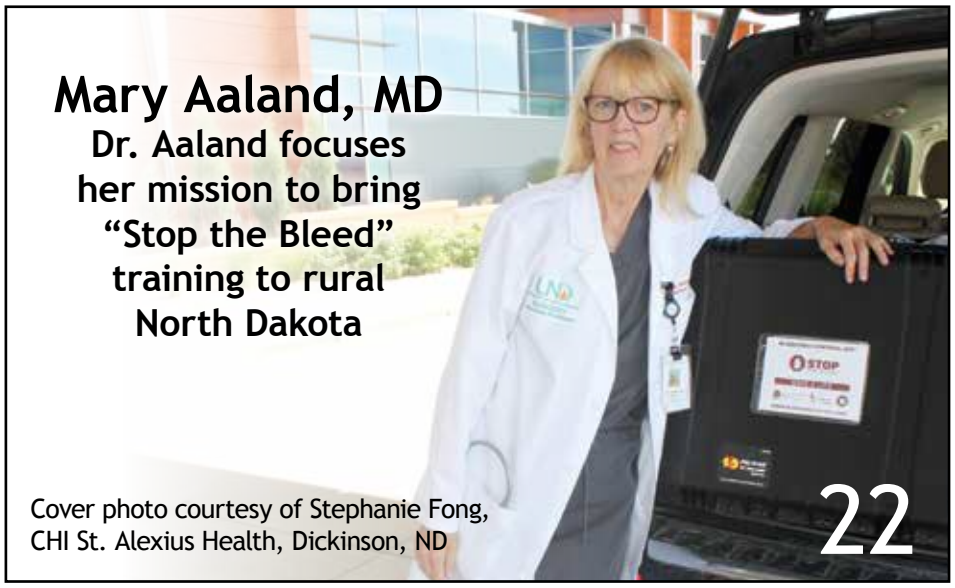
In this Issue



President's Message

Physician Burnout

Fadel Nammour, MD
NDMA President

Herbert Freudenberger, an American psychologist used the term "burn out" for the first time in his 1974 book, Burn Out: The High Cost of High Achievement. He defined burnout as a "state of mental and physical exhaustion caused by one's professional life."

Although there is no agreement on the definition or diagnosis of burnout, it's considered a psychological syndrome characterized by 3 cardinal symptoms: exhaustion, detachment from work related activities and decrease job performance.

Most recent physician surveys showed 42 percent of physicians reported burnout, 15 percent described some form of depression, with their job being the highest contributor for their depression, and suicide rate was among the highest in the nation, more than twice the general population.

Burnout in the healthcare profession has a broader implication and leads to lower patient satisfaction and quality of care, an increase in malpractice risks, a higher turnover, a possible physician's addiction to alcohol and drugs and could be a predictor of depression and an increase suicide rate. All these would translate into worsening population health and increase healthcare costs.

The practice of medicine is and will always be a stressful job. From the start as a medical student and through our years of training, we were taught to always work harder, make no mistakes and do everything ourselves to make sure it gets done right. Patients always come first and there is no room to show any weakness. This mindset continues as a practicing physician. In addition, there is more responsibility, longer working hours, lack of control over your practice, staff shortages, a disconnect with administrative management, government and healthcare system regulations, and a feeling of not being appreciated, making it a fertile ground for burnout.

It is time for physicians and organizations to acknowledge this phenomenon, to prevent it or to detect it early, to provide the necessary support or intervention before it is too late. One most recognized way to prevent burnout is engagement. Some see engagement as "the opposite of burnout", and it brings motivation, dedication and a sense of fulfillment to the workplace. Other burnout interventions include: 1) promoting life balance, good health and fitness, 2) developing coping skills, relaxation techniques and self-awareness, 3) social support from colleagues, friends or family members.

As a physician organization, we understand and believe that to improve the health of North Dakotans and to be able to provide high quality care we need a healthy and engaged workforce. I take this opportunity to thank you for your involvement and time with NDMA and remind you to attend our annual meeting coming this fall, October 4 & 5 in Bismarck, which will feature a presentation on physician burnout.

Preparing for the 66th Legislative Assembly

Courtney M. Koebele, JD
NDMA Executive Director

The legislative session is around the corner and we are diligently preparing for the upcoming onslaught in Bismarck. Our Commission on Legislation, chaired by Sarah Schatz, MD, of Jamestown, has already met this summer, and will be meeting at least twice more before North Dakota's 66th Legislative Assembly commences on January 3, 2019.

NDMA's top concerns will be many of the usual issues– Medicaid and Medicaid Expansion; medical school budget, and probably scope of practice, here and there, but we will have a few issues of our own.

Interstate Medical Licensure Compact (IMLC)

The IMLC is an agreement between 24 states and 1 territory and the 31 Medical and Osteopathic Boards in those states and territory. North Dakota is the only midwestern state not in the Compact. Under this agreement, licensed physicians can qualify to practice medicine across state lines within the Compact if they meet the agreed upon eligibility requirements.

The application process is expedited by leveraging the physicians' existing information previously submitted in their state of principal license (SPL). The SPL will verify the physicians information and conduct a fresh background check. Once qualified, the physician may select any number of Compact states for which they desire to practice. Application cost is a $700.00 fee PLUS the cost of a license(s) selected to practice.

NDMA has existing policy supporting the IMLC and NDMA was part of a coalition supporting the IMLC in the 2017 session. The bill was well received in the Senate and passed unanimously. Unfortunately, the bill failed to pass in the House. North Dakota health systems and physicians are very enthusiastic about joining all the states around us and supporting this proposal in the ND legislature in 2019.

Sports Team Physician Licensure

Another resolution coming from the NDMA House of Delegates is the licensure of sports team physicians. In furtherance of this policy, NDMA has been working with the ND Board of Medicine to develop a bill that would allow a physician licensed in another state to be exempt from the licensure requirements in North Dakota if the physician is employed or formally designated as the team physician by an athletic team visiting North Dakota for a specific sporting event. The visiting physician must limit the practice of medicine in North Dakota to medical treatment of the members, coaches and staff of the sports entity that employs the physician.

Doctor of the Day program allows physicians an opportunity to interact with our North Dakota policy makers – sign up now at *www.ndmed.org*.

Similar bills have been passed in 40 states, impacting roughly 90% of the country. The Federation of State Medical Board policy encourages states to adopt laws that allow visiting sports team physicians to practice on their teams.

Family Planning Nurse Dispensing

NDMA has another opportunity to collaborate with the ND Nurses Association in amending the dispensing law to allow family planning nurses to dispense birth control to family planning patients in rural clinics. Right now, unless the prescriber is physically present with the patient, a nurse can't dispense birth control, even if the prescriber is present by telemedicine. NDMA has been meeting with the ND Board of Nursing and ND Board of Pharmacy, and working with the ND Department of Health to draft an exemption to the pharmacy law to allow this important service.

We can't talk about the 2019 Legislative session without mentioning our Doctor of the Day program. This is an NDMA exclusive – and such an opportunity to interact with North Dakota policymakers. Sign up for Doctor of the day is available on the website right now, or you can call the office and we can sign you up. Check your schedules for 2019 and consider serving!

My motto about the North Dakota Legislature is borrowed from a popular reality show – "expect the unexpected." NDMA is expecting the unexpected and preparing well in advance, to provide the best representation we can for North Dakota's physicians.

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2018 Annual Meeting
October 4-5, 2018

Bismarck Event Center • 315 S 5th Street • Bismarck, ND

This year's NDMA annual meeting is in collaboration with the North Dakota Chapter of the American College of Physicians. The combined effort allows both groups to share educational sessions and increase peer networking opportunities.

NDMA SOCIAL

Hosted by Sixth District Medical Society

Thursday, October 4 · 5:30 p.m.

STONEHOME
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Please join us at this year's NDMA Annual Meeting Social, hosted by Sixth District Medical Society. We encourage all NDMA Annual Meeting participants to attend this evening of networking and fun. The event will take place at the Stonehome Brewing Company's roof top patio, located on the top floor of the new First International Bank on State Street. The outdoor patio features a beautiful skyline view of Bismarck, accompanied by the warm glow of outdoor firepits and comfortable, cushioned seating. Don't miss this opportunity to unwind, mingle and share a laugh or two. Refreshments and food will be served.

Thursday, October 4

3:00 p.m. — **NDMA Council Meeting (Council members only)**
First International Bank & Trust (Second Floor)
1601 North 12th Street, Bismarck, ND

5:30 p.m. — **NDMA Annual Meeting Social Hosted by 6th District Medical Society**
Stonehome Brewing Company,
1601 North 12th Street, Bismarck, ND

Friday, October 5

7:30 a.m. — **Breakfast with the Dean of UND SMHS**
Joshua Wynne, MD, MBA, MPH

8:15 a.m. — **NDMA House of Delegates-First Session**
Reference Committee of the Whole to Follow

9:15 a.m. — **AMA Update: Engaging Physicians in the Future of Health Care Delivery**
Jack Resneck, Jr., MD, Chair, AMA Board of Trustees

10:15 a.m. — **Break**

10:30 a.m. — **Clinical Guidelines: Where Do They Come From and How Should They Be Used?**
Jack Ende, MD, MACP, Immediate Past President, American College of Physicians
- Diabetes: Raul Ruiz, MD, endocrinologist and immediate past speaker at the American College of Physicians ND Chapter Meeting
- Back Pain: Jeff Hostetter, MD, FAAFP, UND Center for Family Medicine and Family Medicine Residency Program Director
- Breast Cancer Screening: Rhonda Schafer-McLean, MD, OBGYN, UND Center for Family Medicine

11:30 a.m. — **Panel Discussion: Understanding Drug Pricing: Formularies, Rebates, and More!**
Greg Hoke, Biotechnology Innovation Organization; Danny Weiss, Sanford Health Plan; Dan Churchill, PharmD; and Brendan Joyce, PharmD

12:30 p.m. — **Awards Luncheon**

2:00 p.m. — **NDMA House of Delegates-Final Session**

2:45 p.m. — **Cut to Cure: When to Call a Surgeon and What to Say When You Do**
Aaron Chalmers, MD, FACS

3:15 p.m. — **Everything I Need to Know I Learned in Prison**
John Hagan III, MD

3:45 p.m. — **Physician, Heal Thyself: Physician Well-Being in Modern Health Care**
Joshua Ranum, MD, FACP

Breakfast with the UND SMHS Dean: Serving North Dakota Today and Tomorrow

Friday, October 5
7:30 a.m.

SMHS Dean Joshua Wynne, MD, MBA, MPH, is the University of North Dakota's vice president for health affairs and dean of the UND School of Medicine and Health Sciences. Wynne joined the UND SMHS in 2004 and assumed his current leadership role in 2010. Under his direction, the School has intensified its focus on meeting the health care workforce needs of North Dakota. Dr. Wynne will provide an overview of changes happening at the School and review plans for the School's future, including the need for the continuing support of NDMA and its member physicians.

House of Delegates First Session

Friday, October 5
8:15 a.m.

As NDMA's policy-making authority, the House of Delegates (HoD) considers resolutions and reports on topics of importance to physicians and patients. Elections will be held for NDMA President, Vice President, Secretary-Treasurer, and Speaker of the House.

Delegates are elected by the district medical societies. Delegates consider and vote on resolutions, which are the foundation for NDMA policy and legislative efforts. All NDMA members may attend HoD meetings and introduce resolutions. ***To introduce a resolution or for assistance in drafting one, contact NDMA at 701-223-9475.***

AMA Update: Engaging Physicians in the Future of Health Care Delivery

Friday, October 5
9:15 a.m.

Jack Resneck Jr., MD, a dermatologist and health policy expert from the San Francisco Bay area, was elected to the American Medical Association Board of Trustees in 2014, and assumed the chair position in 2018. Prior to his election, Dr. Resneck served the AMA as a member and chair of the AMA Council on Legislation and as a delegate to the AMA House of Delegates. Dr. Resneck received his BA in public policy from Brown University and his MD from UCSF where he also completed his internship in internal medicine, residency in dermatology and health policy fellowship. He is active in health services research and his studies have been published in prominent journals and attracted national media attention. Dr. Resneck will describe challenges facing physicians in the delivery of high quality healthcare, prepare for engagement in advocacy to improve health, reduce practice burdens, and make physician careers sustainable for the next generation.

Clinical Guidelines: Where Do They Come From and How Should They Be Used?

Friday, October 5
10:30 a.m.

Jack Ende, MD, MACP, immediate past president of the American College of Physicians , is the Schaeffer Professor of Medicine and Assistant Dean for Advanced Medical Practice at Penn's Perelman School of Medicine. He also serves as Executive Medical Director for Penn Signature Services, Penn Medicine's line of programs that coordinate provision of medical services to international patients, as well as provides consultation services to hospitals and institutions around the world. Board certified in internal medicine, Dr. Ende earned his medical degree from the Medical College of Virginia and completed his residency at the University of Chicago, where he also served for one year as Chief Resident. Dr. Ende will help participants understand how guidelines are developed, including their strengths and weaknesses.

Continuing Medical Education

This activity has been planned and implemented in accordance with the American College of Physicians, accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The American College of Physicians designates this live activity for a maximum of 4.25 AMA PRA Category 1 Credit(s)TM.

Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 4.25 medical knowledge MOC points in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit.

Learning Objectives:
At the conclusion of this activity, the participant will be able to:

- Describe challenges facing physicians in the delivery of high-quality health care.
- Understand how guidelines are developed, including their strength and weaknesses.
- Discuss several common medical problems often considered "surgical" in nature, as well as when and how to involve a surgeon when diagnosing and treating them.
- Understand the burden of physician burnout, appreciate your personal risk of burnout, and identify strategies to promote professional well-being.

Panel Discussion – Understanding Drug Pricing: Formularies, Rebates, and More!

Friday, October 5
11:30 a.m.

The rise of health care costs has lawmakers and employers scrambling to find ways to provide access to care, including prescriptions, while controlling costs. This panel discussion is designed to educate on the basic issues in pharmacy business covering the differences between formularies, discounts, and rebates and what it takes to get a pharmaceutical drug through the system to the end user: our patients.

Panelists

Greg Hoke
Director of State Government Affairs
Biotechnology Innovation Organization

Dan Churchill, PharmD,
Churchill Pharmacy

Danny Weiss
Senior Director of Pharmacy Benefits
Sanford Health Plan

Brendan Joyce, PharmD, R.PH.
Administrator
Pharmacy Services
Medical Services Division
ND Dept. of Human Services

Annual Awards Lunch

Friday, October 5
12:30 p.m.

The 2018 annual meeting luncheon and awards presentation will feature recognition of exceptional service in medicine, including the NDMA Physician Community and Professional Services Award and the Friend of Medicine Award. We will also recognize physicians who have served within the field of medicine for forty years.

NDMA House of Delegates Final Session

Friday, October 5
2:00 p.m.

The House of Delegates (HOD) Reference Committee of the Whole reconvenes for final business. Delegates are encouraged to present testimony, and comment on reports and resolutions.

Cut to Cure: When to Call a Surgeon and What to Say When You Do

Friday, October 5
2:45 p.m.

Aaron Chalmers, MD, FACS, is a general surgery physician with Mid Dakota Clinic in Bismarck, where he has been practicing since 2012. Dr. Chalmers is a clinical instructor of surgery and serves as Assistant Professor of Surgery and Associate Director of the SW Campus at the UND School of Medicine and Health Sciences. He received his education at the University of North Dakota School of Medicine and Health Sciences in Grand Forks, ND, followed by an internship and residency at the University of Wisconsin Hospital and Clinics, Madison, WI. Dr. Chalmers will discuss common medical problems often considered "surgical" in nature, as well as when and how to involve a surgeon when diagnosing and treating them.

Everything I Need to Know I Learned in Prison

Friday, October 5
3:15 p.m.

John Hagan III, MD, staff physician at the North Dakota Department of Corrections, serves as a primary care provider and supervises clinical, primary care and psychiatry. Dr. Hagan also serves as Vice Chair of the Department of Internal Medicine for the University of North Dakota School of Medicine and Health Sciences. He received his MD at Boston University School of Medicine and a Bachelor's Degree in Biophysics at Johns Hopkins University. In this session, participants will recognize patients' antisocial behavior as an opportunity to apply motivational interviewing techniques to achieve positive therapeutic outcomes.

NDMA OFFICER ELECTIONS

NDMA members nominated for 2018-2019 officer positions are listed below.

Candidates may be nominated from the floor during the morning House of Delegates session.

PRESIDENT
Fadel E. Nammour, MD
Fargo, ND
Nominated by
1st District Medical Society

VICE PRESIDENT
Misty K. Anderson, DO
Valley City, ND
Nominated by
5th District Medical Society

SECRETARY-TREASURER
Joshua C. Ranum, MD
Hettinger, ND
Nominated by
11th District Medical Society

SPEAKER OF THE HOUSE
Stephanie K. Dahl, MD
Fargo, ND
Nominated by
1st District Medical Society

Physician, Heal Thyself: Physician Well-Being in Modern Health Care

Friday, October 5
3:45 p.m.

Joshua Ranum, MD, FACP, internal medicine physician with West River Health Services in Hettinger, ND, received his medical degree from the University of North Dakota School of Medicine, Grand Forks, interned at Altru Health in Grand Forks and completed his Internal Medicine residency at Grand Rapids Medical Education Partners in Michigan. He also serves as Clinical Assistant Professor of Internal Medicine at the University of North Dakota School of Medicine and Health Sciences and is the Rural Opportunities in Medical Education Site Coordinator. In 2016, Dr. Ranum received the Dean's Special Recognition Award for Outstanding Volunteer Faculty from UND School of Medicine, and most recently received the Emerging Rural Health Leader Award from the Dakota Conference on Rural and Public Health. In this session, Dr. Ranum will help participants understand the burden of physician burnout, assess personal risk of burnout and identify strategies to promote professional wellbeing.

Annual Meeting Registration Form

First Name _____ MI _____ Last Name _____

Organization _____

Mailing Address_____

City _____ State _____ ZIP _____

Telephone _____ Fax _____ E-mail _____

Guest(s) First/Last Name _____

Registration Fee: $50—includes the Friday conference day breakfast, lunch and educational credit costs. Please indicate below which events you will be attending. If you choose to participate in only the House of Delegates session(s), there is no registration fee.

_____ **Number attending Thursday, October 4 evening NDMA Social**

_____ **Number attending Friday, October 5 breakfast**

_____ **Number attending Friday, October 5 educational program**

_____ **Number attending Friday, October 5 luncheon**

_____ **I will ONLY attend the House of Delegates meetings**

I wish to contribute to the NDMA PAC (Suggested donation $200) $ _____

_____ **Number attending annual meeting @ $50 per person** $ _____

Total Amount Enclosed $ _____

CONFERENCE CANCELLATION POLICY: No refunds after October 1, 2018.

NDMA ANNUAL MEETING DELEGATE HANDBOOK:

❒ Check here if you **DO NOT** want a printed book, and prefer to download your own electronic copy from our website: *www.ndmed.org*

Please mail this form along with payment no later than October 1, 2018 to:

NDMA, 1622 E. Interstate Ave., Bismarck, ND 58503-0512

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LODGING

A block of rooms has been reserved for Thursday, October 4th, at the Radisson Hotel located at 605 East Broadway Avenue, Bismarck, at the low rate of Single/Double room for $92.00 US, plus tax.

For reservations, contact the Radisson at 701-255-6000, or reserve online at *Radisson.com*: enter: Destination, Check In Date, Check Out, Date, Number of Adult, and Enter Booking Link: NDMA18. Select Radisson and enter for search.

Reservations must be received by September 20, 2018. Cancellation policy: 24 hours before the day of arrival.

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We've always believed in hiring the best to create exceptional teams. In February, we hired Renee Daffinrud as a Private Banker. Renee brings 35 years of banking experience. She has worked with student loans, consumer loans, mortgage loans, business banking, and investments. This extensive background gives her the expertise to be able to create a plan, and partner with a team of specialists in mortgage, insurance, and wealth management. Renee helps clients reach their personal and financial goals today, and into the future. Contact Renee at 701-751-8511 or email her at *RDaffinrud@firstintlbank.com* to learn more about private banking services.

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2018 AMA Annual Meeting Delegate Report

By Shari Orser, MD and Michael Booth, MD

NDMA American Medical Association (AMA) Delegate Shari Orser, Alternate Delegate Michael Booth, along with executive director Courtney Koebele, joined physicians from around the country in Chicago to attend the 2018 AMA Annual Meeting.

The 2018 AMA Annual Meeting was filled with discussion on big topics facing the medical community and the country. U.S. Surgeon General Jerome Adams, MD, a special guest at the meeting, gave a speech encouraging AMA members to lead the nation in a civil discussion on pressing issues, such as gun violence, substance-use disorder and health equity.

Dr. Adams, an AMA delegate, encouraged physicians to look "upstream for root causes and preventative solutions" to substance-use disorders and other health issues. Noting that he joined the AMA 20 years ago, he said that the experience "lit a fire," helping him to develop into a physician leader.

Patrice A. Harris, MD, an Atlanta psychiatrist, won the office of AMA president-elect. Dr. Harris, chair of the AMA Opioid Task Force, is the first African-American woman to hold the office. And new AMA President Barbara L. McAneny, MD—the first oncologist to hold the office—said in her inaugural address that the U.S. health system is ailing, but that doctors are perfectly positioned to fix it. Patients, she said, are counting on physicians "to step up and create a system that is worthy" of their trust.

NDMA AMA Delegate Shari Orser, MD, and Alternate Delegate Michael Booth, MD, working on the business at the 2018 AMA Annual Meeting.

Here is an overview of other policies adopted at the meeting:

Common-sense measures to prevent gun injuries and deaths

- Establishing laws allowing family members, intimate partners, household members and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence.
- Prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking from possessing or purchasing firearms.
- Requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons.
- Requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System.

The delegates also modified existing policy to:

- Recognize the role of firearms in suicides.
- Encourage the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling.
- Encourage physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Boost affordability, competition in ACA marketplaces

Nearly 12 million people obtained coverage through the Affordable Care Act marketplaces this year. The AMA adopted policies to improve the exchanges including:

- Providing adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits.
- Expanding eligibility for premium tax credits up to 500 percent of the federal poverty level.
- Providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income.
- Encouraging state innovation—this includes consideration of state-level individual mandates and auto-enrollment and/or reinsurance— to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections.
- Establishing a permanent federal reinsurance program

The AMA 2018 Annual Meeting provided great networking opportunities. Pictured left to right: Mike Flesher, CEO, Iowa Medical Society; Courtney Koebele, Executive Director, North Dakota Medical Association; Dale Mahlmen, EVP; Nebraska Medical Association; Janet Silversmith, CEO, Minnesota Medical Association; and Barb Smith, CEO, South Dakota Medical Association.

Look upstream for root causes and preventative solutions

Road map for health care Augmented Intelligence (AI)

In its first time addressing the topic of "augmented intelligence," the AMA laid out a road map for health care augmented intelligence (AI) to ensure quality and protect patient rights. As a result of the AMA House of Delegates' (HOD) first time adopting policy on the topic of AI, the AMA will seek to leverage its ongoing engagement in digital health and other priority areas. The focus will be to improve patient outcomes and physicians' professional satisfaction and to help set priorities for health care AI and identify opportunities to integrate the perspective of practicing physicians into the development, design, validation and implementation of health care AI.

Remove barriers to opioid-use disorder treatment

- Advocate for legislation to eliminate barriers to increase funding and access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities.
- Develop a campaign to increase public awareness that medical treatment of substance-use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.

Physicians adopt plan to combat pay gap in medicine

With reports showing persistent male-female disparities in pay among all specialties even after accounting for age, experience, faculty rank, and measures of research productivity and clinical revenue, the AMA HOD took sweeping action to study, act and advocate to advance gender equity in medicine and within the AMA.

- Advocate institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation.
- Advocate that pay structures be based on objective, gender-neutral criteria.
- Encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics and actual total compensation for all employed physicians.

Precision medicine should have its play in new pay models

Citing the movement to a health care system that is rooted in value-based care, the AMA committed to working on integrating precision medicine into alternative payment models (APMs).

A report from the AMA Council on Medical Service touted precision medicine—a tailored approach to health care that accounts for individual variability in the genes, environment and lifestyle of each person—for having the "potential to revolutionize diagnosis and treatment of disease and, in doing so, improve health outcomes downstream."

The implementation of that individualized approach in APMs, which emphasize cost efficiency, is stymied somewhat by the front-end price tag of certain precision medicine techniques.

To address the cost challenges associated with that integration, the AMA HOD adopted new policy that:

- Affirms clinical pathways should be developed by clinical experts, including national medical specialty societies, and should be leveraged by or integrated into electronic health records (EHRs) for decision support, seamless documentation, and automation of communication with payers for authorization.
- Encourages alternative payment models to incorporate evidence-based clinical pathways as appropriate and as recommended by national medical specialty societies.
- Encourages APMs to integrate precision medicine approaches, where appropriate, to improve the diagnostic process and personalize patient care.
- Encourages APMs to measure patient outcomes and quality improvements over time to allow for the use of precision medicine tests and therapeutics that have clinical value.

Doctors oppose policy that splits kids from caregivers at border

The AMA HOD Delegates adopted new policy for the AMA to oppose the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child's well-being.

Inspiring Our Patients (and Ourselves) to Develop Healthier Lifestyles:

Do Metrics Help Motivate Behavior Change?

By Melanie Carvell, PT

As a physical therapist, it is a common scenario: a patient arrives for their return visit, only to spend the first part of the therapy session reporting all the reasons they didn't have time or energy to do their prescribed home exercise program. Sticking with an exercise prescription is not easy. Does promoting "exercise is medicine" as key to improving health metrics inspire patients to make long-lasting behavior changes? We, as providers, must find ways to sell the benefits of moving more so that our patients buy it.

Mountains of research demonstrate the many physical and mental benefits of moving more. The challenge is to start, and, more importantly, to keep physical activity as a consistent part of life. Dr. Michelle Segar, a behavioral sustainability and motivation scientist at the University of Michigan, has studied the most critical issue facing our society: the failure to achieve wide-spread adoption of health-promoting and disease management behaviors. Dr. Segar's research shows that our "meaning" of exercise is a critical determinant of how successful we will be in maintaining a physically active lifestyle. Thinking of exercise as a chore you have to do or should do, undermines motivation before you even start. Dr. Segar's research shows that if your number-one reason for starting an exercise program is to lose weight, you will unlikely be successful maintaining your exercise routine. Participants in her research who exercised to "lose weight" actually did the least amount of activity. While it is logical to promote exercise for health benefits like weight loss, behavioral research proves that logic does not motivate as well as emotion.

Consider the scenario of two young, overweight men who are planning to start exercising again. "Charlie" is planning on returning to regular exercise on his lunch break. He used to play noon basketball at the local YMCA, but after the birth of his son his life became very busy, and his weight crept up as his exercise program took a back seat. His "why" for returning to exercise includes re-connecting with his noon-hour workout buddies and finding a way to gain energy, increase his work productivity, and reduce stress. He also wants to be a healthy and active dad to set a good example for his new son.

"Clark" has just seen his health care provider and was diagnosed with high blood pressure and prediabetes. He was encouraged to start exercising and eating healthier to lower his weight, blood pressure, and blood sugar. He needs to change his habits or he is likely to need prescription medicine to help get his metrics moving in the right direction. Clark feels like moving more is something he "has to do" or "should do." Which of these men is more likely to stick with his exercise goal?

Unfortunately, the most common reason for exercising—to lose weight—is the least helpful for many of our patients who jump on the diet and fitness bandwagon, only to get frustrated and quit before they get any benefit. This cycle is often repeated, resulting in frustration for both patients and their health care providers. Weight loss and other health metrics such as healthy blood pressure, blood sugar, and cholesterol profiles are critically important, but the promise of good health down the road rarely gets us out of bed and moving today. Research proves that goals alone don't motivate behavior until they have a personal meaning. Guilt, doctors' orders, and even dire health consequences are unlikely to inspire lasting changes. Choosing the right "why," one that resonates with us personally, is the most important step on the path to better health.

Rather than focusing on the bathroom scale, help patients find their "why" for starting an exercise program, focusing on the daily positive rewards of being more active: decreasing stress, gaining strength and energy, and improving mental focus and vitality. Goals that connect with patients emotionally are much more likely to inspire lasting change. The ability to be healthy enough to be active with kids and grandchildren can be a powerful motivator and can inspire a legacy of good health habits for future generations.

The number one predictor of optimal physical, mental, and spiritual health is how connected we are to others. If we have strong social connections we are twice as likely to have a healthy heart profile. Connectedness strengthens our immune system, decreases inflammation, helps us recover faster from disease, and lowers our levels of anxiety and depression. Socialization is the number one exercise adherence tool. Being active

Melanie Carvell is an inspirational speaker whose compelling presentations energize her audience with practical solutions, humor, and storytelling. She is a six-time All-American triathlete, a physical therapist, certified Worksite Wellness consultant, and author of Running with the Antelope; Lessons of Life, Fitness and Grit on the Northern Plains. Melanie was named Sanford Health's "Manager of the Year" in 2016 and just recently named one of the state's "Leading Ladies" by the North Dakota Women's Center for Technology and Business.

with someone else is one of the best ways to ensure we get moving ourselves, and we are also much more likely to exercise more intensely. Encourage patients to become physically active for what they will gain, rather than what they want to lose.

As humans, we are hard-wired for instant gratification and are likely to sustain behaviors only if they have an immediate benefit to our daily life. The best determination of how likely our patients are to be successful keeping active is by helping them appreciate how moving more can add to their life today. As a result, they will be much more likely to stick to their exercise commitment, which gives them a fighting chance to benefit from improved health metrics, and a happier, more fulfilling life. Rather than thinking of exercise as only a necessary tool for weight loss or other metrics, look beyond that. Encourage exercise for sanity, not vanity. Reinforce the fact that the most important benefit of a healthy lifestyle is happiness. Think of daily movement as the personal power source that fuels life and our many roles in it.

Navigating the Process of Unproven Stem Cell Practices in North Dakota

A summary of how it was done by NDMA member Duncan Ackerman, MD.

Duncan Ackerman, MD
Orthopaedic Surgeon, Bone & Joint Center

Regenerative medicine and the utilization of stem cells to treat countless diseases has exploded over the past several years. The science and purpose seem promising but proving the efficacy and what types of cells to utilize for a particular disease process is still challenged. Physicians have been performing autologous cell transfers for patients; however, most physicians would agree this practice is less controversial than non-autologous (e.g. umbilical cord blood) utilization.

Over the past year and a half, as a member of the American Academy of Orthopedic Surgeons Board of Councilors, I have heard countless stories from colleagues reporting the practice of injecting non-autologous stem cells into patients and have most recently seen similar activity in North Dakota. Therefore, this story outlines our experience in stopping the practice of non-autologous stem cell injections in North Dakota.

The story began I'm sure quite similar to other places in the country. A chiropractor, not licensed in North Dakota, opened a clinic in one of our larger communities. The clinic, managed by a non-medical provider, held free seminars across North Dakota where participants were presented with an aggressive sales pitch. Seminar participants were given information about failure rates of multiple orthopedic procedures and were sold this injection as a nonsurgical option. Participants were also shown x-rays that showed dramatic radiographic improvement following the stem cell injections.

The stem cell injection patients were receiving was a derivative of umbilical cord tissue and blood. The website for this product specifically states that it is not a Food and Drug Administration (FDA) approved product and does not claim treatment with the product as a cure for any condition, disease, or injury. The participants, now patients, were injected by Advanced Practitioners employed by the clinic. The cost of the injections was variable and based upon how much the patient could afford, ranging from around $5,000 for a knee injection and upwards of $20,000 for a series of injections in multiple body areas. If the patient told the clinic they could not afford a specific amount the price quickly dropped to capture the patient.

The increase in patients questioning the use of stem cells in our orthopaedic clinic prompted further inquiry into the stem cell clinic. When our clinic patients asked why we didn't perform non-autologous stem cell injections, we educated them on stem cell science, the indications and efficacy. We explained to patients that we get paid less for a total knee arthroplasty as a surgeon than the cost of a knee injection at the stem cell clinic.

Realizing this was a patient safety issue, the Bone & Joint Center, along with the North Dakota Medical Association reached out to the ND Attorney General's Office (NDAG), Consumer Protection Division.

Realizing this was a patient safety issue, the Bone & Joint Center, along with the North Dakota Medical Association reached out to the ND Attorney General's Office (NDAG), Consumer Protection Division. The NDAG had also received some inquiries from consumers regarding the ads and the clinic and had started an investigation. As time went by, more patients were contacting the NDAG to file formal complaints against the stem cell clinic. The NDAG was in communication with multiple medical entities in North Dakota throughout this process. In a meeting with the affected medical boards it was confirmed that the NDAG would proceed with legal action, if necessary, to resolve the matter above.

The focus of the investigation was demonstrating proof that the efficacy of the procedure was based on sound scientific principle and data. The stem cell clinic was unable to provide documentation to support the way they were using the injections. In addition, the clinic could not provide any supporting documentation that substantiated many of the comments made to the patients. Comments ranged from "end your pain now" to "we can literally regenerate any cell in your body."

Upon conclusion of its investigation, the Attorney General was preparing to bring legal action to enjoin the stem cell injections and alleged misrepresentations. The Attorney General, however, reached a settlement of its claims that the clinic violated North Dakota Century Code

(N.D.C.C.) chapter 51-15, commonly referred to as North Dakota's "Consumer Fraud Law" in regard to the clinic's misrepresentations of its services. The Attorney General filed the settlement agreement with the state district court, resulting in a court order enjoining the clinic from engaging in the stem cell injections and misrepresentations, and requiring the clinic to pay civil penalties to the State of North Dakota and make refunds to some patients.

In addition to the complaints against the clinic, the NDAG Consumer Protection Division approached the two Advanced Practitioners with similar concerns and results. The NDAG also alleged they were in violation of the consumer fraud law for: 1) representing, expressly or implied, to their patients that the stem cell injections are safe, effective, beneficial, and in the best interest of the patient, without sufficient evidence to substantiate such a claim; 2) Advising, recommending, and administering to patients a product without sufficiently reviewing information about the product. The NDAG obtained separate agreements with the Advanced Practitioners, filed with the state district court, and resulting in a court order enjoining the Advanced Practitioners from making the stem cell injections, making any misrepresentations, and requiring payments of civil penalties to the State of North Dakota.

Our experience in North Dakota seems to be one of the few successes in this arena thus far. I personally feel we as physicians need to be our patients advocates and protect them from significant financial loss and possible physical harm. If you hear a patient with a problem or bad experience encourage them to report the issue to the NDAG Consumer Protection Division. I believe it is helpful for the NDAG to be aware of patient complaints and concerns, as well as the concerns of the medical community.

Please reach out to me with any questions. I am also willing to help any way I can.

Dr. Bakke Appeals to Physicians to Strongly Recommend HPV Vaccine for Patients. *HPV vaccine prevents cancer. And that's good news.*

Rebecca Bakke, MD, FAAP

One of the most dreaded tasks of the physician is to deliver bad news. As a pediatrician I do plenty of this; informing parents about birth defects or developmental delays, telling families that their child has a serious condition that requires hospitalization, or disclosing to an adolescent that she has acquired a sexually transmitted infection that will affect her for a lifetime. While the specifics of these conversations vary from specialty to specialty, we all deliver bad news. The most frustrating conversations occur when the bad news could have been easily avoided; we all know that insulin prevents diabetic ketoacidosis, seatbelts prevent brain injuries and abstaining from cigarettes prevents lung cancer, and we counsel our patients accordingly. We now have a vaccine that prevents a virus that will affect nearly 1 out of 2 Americans. The bad news? Our patients aren't getting it.

The vaccine against Human Papillomavirus (HPV) was FDA approved in 2006. HPV is ubiquitous, and will infect up to 90% of the population at some point. While some will clear the infection without sequelae, others will have repercussions that last a lifetime. In "minor" cases patients may develop genital warts or cervical dysplasia. But thousands of women and men will develop cancer in a multitude of sites—oropharyngeal, penile, anal and cervical cancers are all caused by HPV. Every year, 12,000 American women are diagnosed with cervical cancer and 4,000 will die from the disease. We could prevent 90% of cervical cancer alone through HPV vaccination.

The vaccine is nearly 100% effective. It is also incredibly safe. Over 100 million doses have been given in the United States. Post-market surveillance studies have been done in literally millions of men and women, and despite rampant internet rumors, the vaccine is not linked to fertility problems, autoimmune disease, blood clots, or any side effects more severe than a sore arm.

So, we have an effective vaccine that safely prevents a virus that can lead to cancer and death. Why aren't our patients getting it? We would like to point a finger at the celebrities and politicians who ignorantly and recklessly preach against vaccines, parents who are naive to the common realities of young adulthood or a culture that is increasingly skeptical of Western medicine, and certainly these factors play a role. But the bad news is, we need to take our fingers and point them squarely back at ourselves. Studies show that one of the main reasons our HPV vaccination rates are so low is that physicians are not recommending it. Patients consistently identify their physicians as their primary source of information about vaccination. Evidence indicates that vaccine uptake is best when it is recommended strongly and unambiguously: Don't ask your patients if they want the vaccine, tell them they need it, and be prepared for any questions that may follow. Your message should be that the HPV vaccine prevents cancer. And that's good news.

The American Cancer Society recently launched the **Mission: HPV Cancer Free campaign** (*pressroom.cancer.org/HPVcancerfreelaunch*) , which seeks to increase HPV vaccination rates for pre-teens. Visit *www.cancer.org/hpv* to learn more.

American Cancer Society Updates Colorectal Cancer Screening Guideline

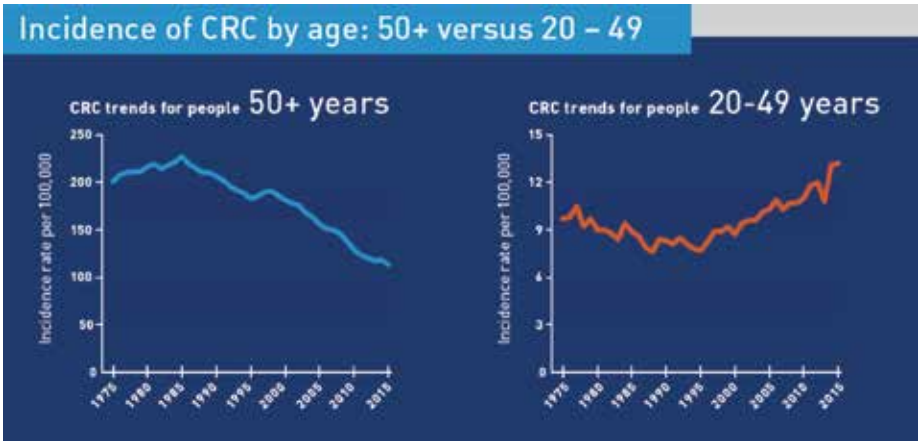
The American Cancer Society (ACS) recently published an updated guideline recommending that colorectal cancer (CRC) screening begin at age 45 in adults of average risk. This change was based in part on data showing rates of CRC are increasing in young and middle-aged populations. While CRC incidence has declined significantly in those age 50 and older, there has been a 74 percent rise in incidence among individuals under age 50 since 1988. This trend is displayed in the table below.

Shannon Bacon,
American Cancer Society, Inc.

There has been a 74 percent rise in incidence among individuals under age 50 since 1988

North Dakota is following a similar trend in CRC cases among younger adults. The new recommended screening start age is based on these CRC incidence rates, results from microsimulation modeling that demonstrate a favorable benefit-to-burden balance of screening beginning at age 45, and the expectation that screening will perform similarly in adults ages 45 – 49 as it does in adults for whom screening was already recommended (50 and older).

The updated guideline does not prioritize among screening test options but instead emphasizes the importance of patient preferences and choice. The guideline stresses that when a screening test other than colonoscopy comes back positive, it must be followed with a timely colonoscopy in order to complete the screening process. No matter which test gets done, the most important thing is to get tested. Evidence shows that if adults are adherent to an annual Fecal Occult Blood Test (FOBT) with a high-sensitivity test, long-term outcomes are similar to those that are estimated to be achieved with a colonoscopy.



http://nccrt.org/resource/risk-assessment-and-screening-toolkit-to-detect-familial-hereditary-and-early-onset-colorectal-cancer/

The full recommendation article can be viewed online in *CA: A Cancer Journal for Clinicians*, a peer-reviewed journal of the American Cancer Society. To view an issue brief related to the updated guideline, visit *www.nccrt.org* and click on "resources." One of the most common questions we've received in North Dakota is related to how this guideline will impact insurance coverage. The issue brief explains:

"While ACS has updated its guidelines to call for colorectal cancer screening to begin at age 45, health insurance plans may not yet cover the screening test for those in that age range. This could result in out-of-pocket expenses. The Affordable Care Act requires insurance coverage without cost-sharing based on recommendations issued by the United States Preventive Services Task Force (USPSTF). The USPSTF last updated its recommendations in 2016, and recommends individuals begin screening at age 50. While insurers could choose to offer coverage of colorectal cancer screening tests earlier, they are not currently required to do so. The ACS and ACS Cancer Action Networks are working aggressively to educate insurers, lawmakers, and other stakeholders on the rising rates of CRC among younger individuals, the evidence in support of screening for individuals aged 45-49, and the importance of expanding insurance coverage of screening for this age group. Consumers should understand what options their insurance policy will cover and what out-of-pocket expenses they may incur should they begin screening at age 45. Consumers should also understand that there are many screening options, and they may find some screening options more affordable than others, if they need to pay out of pocket before health plans have an opportunity to modify their coverage.

For more information about the guideline, please contact your local American Cancer Society at *shannon.bacon@cancer.org* or 701-433-7593.

Did You Know? You Can Answer "No."

Every year, when you renew your license with the North Dakota Board of Medicine, or when you first apply, you come across two questions like this:

- Have you been treated for any physical, mental or emotional condition which impaired or could be said to impair your ability to practice safely and competently?
- Do you currently have or since the time of your last application renewal have you had a dependency on the use of or engaged in the excessive or habitual use of alcohol or drugs which impaired or does impair your ability to practice medicine safely and competently?

Did you know, you can answer "No" to both questions if you're participating with us at NDPHP (the North Dakota Professional Health Program) or a physician's health program in another state?

If you've signed an intent to participate with us, and are compliant in the program, you can legally answer "No" to these two questions.

The North Dakota Century Code Backs This Up

Here's the full text of North Dakota Century Code 43-17.3 for your reference:

> A licensee, who is participating in, or who has completed a contract for treatment with and has been discharged from, the physician health program, who is in full compliance with all facets of the treatment plan, or has completed treatment and is compliant with aftercare, ***may answer in the negative*** on any question on the application to the board for licensure or licensure renewal regarding current impairment by that condition or those conditions for which the licensee is currently participating in or has been discharged from the physician health program.
>
> However, any recurrence of the impairing condition or conditions or the existence of other potentially impairing conditions that are not currently known to the physician health program must be reported on the application.

What Does This Mean for You?

If you are licensed through the North Dakota Board of Medicine, are a physician assistant student or are a medical student dealing with alcohol or substance use issues, or impairing physical, mental or emotional conditions, NDPHP is here to help you. We've helped many health care professionals, giving them healing and hope for the future.

Your privacy and confidentiality is extremely important to us. We keep all voluntary involvement with us strictly confidential.

Take the first step toward healing and wholeness by visiting *www.ndphp.org* or calling 701-751-5090.

News from the Dean

UND SMHS Launches 2019 Academic Year

The 2019 academic year is off and running at the UND SMHS! As you probably know, universities typically begin their academic year on July 1, and the University of North Dakota is no exception. It also turns out—conveniently—that UND's fiscal year also runs from July 1 to June 30, as does that of North Dakota (where state agencies like UND and the SMHS operate on a biennial budget since our legislature only meets in odd-numbered years). There is a palpable sense of excitement around the School and at our regional campuses with the start of the new academic year and the impending arrival of incoming and advancing students.

So what are SMHS priorities as we begin the new academic year (and my tenth as dean, if my first year as interim dean is included)? Most important of all is to maintain (and improve!) the high quality education that we provide to the roughly 1,500 undergraduate and graduate students who trust us to prepare them for health careers. Second, we plan to continue implementing the Healthcare Workforce Initiative that is improving the delivery of healthcare in the state by reducing disease burden, training more healthcare providers, keeping more graduates within the state for practice after graduation, and improving the efficiency of our healthcare delivery through the wider use of interprofessional teams. Finally, we will continue to expand our research programs that are focused on diseases of relevance to North Dakotans, like opioid addiction, obesity, neurodegenerative disorders such as Alzheimer's and Parkinson's, and cancer.

To carry out our tripartite mission of education, service to the community, and discovery, here are our specific goals for 2019 academic and fiscal year:

1. Ensure adequate appropriated funding support for the School and our programs from the upcoming North Dakota Legislative Assembly—As you know, the state faces some economic challenges, and Governor Burgum has requested that agencies like the School submit a budget that is ten percent lower than the current budget (along with a three percent contingency holdback). Laura Block, our Associate Dean for Administration and Finance/CFO/COO, has been working with Jed Shivers, UND's newly recruited Vice President for Finance and Operations, and the North Dakota University System office to prepare our budget request for the upcoming legislative session. The legislature has been extremely supportive of the SMHS in the past, and I am confident that it will do everything possible so that we can continue our various programs and projects.

2. Continue to work with UND, the legislature, and our generous donors to mitigate student debt—Debt is one of our students' major stresses, and we've worked hard to keep debt as manageable as possible for our students. In fact, over the past few years we've been able to reduce the accumulated debt of our medical students, while debt has gone up on average at most other medical schools in the United States. Since one of our most important goals as an institution is to get more providers into rural areas, limiting debt is a key element in achieving this goal.

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

3. Expand our research efforts, focusing on diseases and issues that are important to North Dakotans—In this regard, I'm very pleased to indicate that shortly we will be expanding our efforts utilizing telemedicine and other so-called virtual care delivery methods so that we can—through collaborations with our affiliated health care systems—bring the clinic to patients (like rural patients) who have difficulty getting to providers. Thanks to a magnificent new donation from alumnus Dr. David Monson and his wife Lola, I'm pleased to announce the start of this initiative that will bring together faculty from UND (along with selected faculty at NDSU and elsewhere) to develop and study novel methods of virtual care delivery.

Quite an agenda to be sure; but thanks to our dedicated faculty and staff, the strong support of our donors, the fantastic direction we get from our SMHS Advisory Council, exceptional funding from the legislature, the wonderful efforts of our volunteer clinical faculty across the state, the help and support we get from UND administration led by President Kennedy, and the gratifying relationships SMHS has with people from across North Dakota, we are excited to welcome our newest crop of students this academic year. It promises to be a great one!

Being really close helps a lot of people see a lot better.

Dakota Lions Sight & Health is the only non-profit full service eye bank in the Dakotas. With four local offices and dedicated on-call recovery staff, you and your patients benefit from some of the **fastest response times** in the nation. And with our advanced cornea preparations, including Preloaded DMEK tissue options, it's easy to **see the big advantages** of working with and supporting your local eye bank.

Dakota Lions Sight & Health
Eye and Tissue Donation

dakotasight.org

DEATH TO PRESERVATION RECOVERY COMPLETION

DLSH COORDINATED DONORS & CORNEAL TRANSPLANTS

Hometown Heroes

LEARN TO STOP THE BLEED

Four months after 26 people were killed at Sandy Hook Elementary School in Newtown, Connecticut, in 2012, the American College of Surgeons called a meeting of senior leaders in the communities of medicine, law enforcement, emergency medical services, fire-rescue, and the military in Hartford, Connecticut. The group was tasked with generating policies that would improve victim survivability at future traumatic events. This led to the creation of the Hartford Consensus documents and the 'Stop the Bleed' campaign was initiated. The purpose of the campaign is to build national resilience by better preparing the public to save lives following everyday emergencies and man-made and natural disasters. Advances made by military medicine and research in hemorrhage control spearheaded the work of this initiative by using the knowledge and same techniques to benefit the general public. 'Stop the Bleed' is a registered service mark of the Department of the Defense. The only thing more tragic than a death from bleeding… is a death that could have been prevented.

STOP THE BLEED®

By Donna Thronson, NDMA Communications Director

Uncontrolled bleeding is the leading cause of preventable death from trauma and no matter how quickly emergency responders arrive at the scene of an accident, bystanders - or everyday ordinary people – will always be first on the scene. A person can die from blood loss within five minutes, making it critical to quickly stop blood loss and people closest to us – our own community members - are best positioned to give the first care.

Driven by passion to improve healthcare access in rural communities, Mary Aaland, MD, FACS, associate professor of Surgery, director of Rural Surgery, and director of Clinical Research at the UND School of Medicine and Health Sciences, focuses her mission on bringing the American College of Surgeons (ACS) Stop the Bleed training program to rural North Dakota.

Photo courtesy of Dickinson Press

According to Dr. Aaland, some of the leading causes of trauma deaths are motor vehicles, gunshot wounds, and motorcycles and since North Dakota is a very rural state, having people trained in rural communities could be the difference between living and dying.

"In a life-threatening bleeding situation, it's like playing the odds," said Dr. Aaland. "Because emergency responders aren't always nearby, the more people who know how to stop the bleeding, the greater the chances are of surviving that injury."

In addition to knowing how to stop the bleeding, having access to bleeding control kits is paramount. "The combo of having the proper training and having access to bleeding control kits can make a life-saving difference," said Dr. Aaland.

Furthermore, Dr. Aaland points out that it's important for people to have the Stop the Bleed kits with them while traveling and in their homes. "Right now, our biggest obstacle is finding enough funding for the kits," said Dr. Aaland. "In North Dakota, when nearly 90 percent of fatal crashes happen on rural roads, having access to a kit can save a life."

A North Dakota Department of Transportation report verifies the statistics. Motor vehicle crashes are the leading cause of injury-related deaths in North Dakota – a rate that is consistently higher than the national rate. According to

Dr. Aaland teaches Stop the Bleed in Tioga.

Photo courtesy of the Tioga Tribune

North Dakota vs. United States Vehicle Fatalities and Vehicle Fatality Rate 2007-2016

Year	ND Fatalities	ND Fatality Rate*	U.S. Fatalities	U.S. Fatality Rate*
2007	111	1.44	41,259	1.36
2008	104	1.37	37,423	1.26
2009	140	1.76	33,883	1.15
2010	105	1.26	32,999	1.11
2011	148	1.61	32,367	1.10
2012	170	1.68	33,561	1.13
2013	148	1.47	32,850	1.11
2014	135	1.29	32,675	1.07
2015	131	1.30	35,092	1.12
2016	113	1.16	**	**

*Number of fatalities per 100 million vehicle miles traveled.
** National fatality data was not available.

the report, the increasing number of people, drivers and vehicles in North Dakota over the past 10 years has led to an increase in miles traveled and ultimately increases risk of crash exposure. The more people, drivers, vehicles and miles driven, the greater the exposure to the risk of a crash. Another critical factor that comes into play is that 80-90 percent of fatal crashes happen on our rural roads.

When it comes to rural development work, it is unlike any other. It requires a special kind of passion and commitment. It is a job that is challenging and humbling, and yet rewarding. Dr. Aaland's passion to improve the lives of rural North Dakotans by focusing on trauma and rural surgery support programs quickly led to her to focus on the basics: *training rural residents to stop the bleeding.*

According to Dr. Aaland, people can be trained to do this with a one-hour course. You don't need medical experience and there is no test.

In addition to the already-mentioned credentials, Dr. Aaland also serves as Governor to the American College of Surgeons Advisory Council for Rural Surgery. It was in 2015 when the American College of Surgeons began working with the National Association of Emergency Medical Technicians to create the Bleeding Control Basic class, a one-hour long course designed to save lives by treating life-threatening hemorrhage. Prior to this, no course existed to teach laypeople the way Cardiopulmonary Resuscitation (CPR) is taught.

"The American College of Surgeons Stop the Bleed program, can be compared to what CPR is to the American Heart Association," said Dr. Aaland.

Specifically, the class teaches how to control bleeding using direct pressure, wound packing, and tourniquet application. Since 2015, the bleeding control course has been delivered to more than 100,000 people in every state in America and in multiple countries worldwide. More than 10,000 instructors have been certified.

To carry her mission through, last summer Dr. Aaland convinced the West River Health Services Foundation (WRHS) to host a Stop the Bleed event in Hettinger. WRHS Foundation was able to successfully round up about 80 people from surrounding communities who generously volunteered their time.

"To make an event successful, you need to find a local champion," said Dr. Aaland. "Someone who can organize a community and find resources to buy the kits."

A local champion can motivate the community to participate and can also locate funding sources to purchase Stop the Bleed kits for participants. According to Dr. Aaland, kits cost around $70 each.

WRHS Foundation Director Ted Uecker proved to be a great champion. Participants ranging in age from 9 to 80 came from Hettinger, Reeder, Lodgepole, Mott, Bowman, Scranton, Carson, Lemmon, Morristown, Meadow, and Bison. In addition, the WRHS Foundation and the American College of Surgeons Foundation generously

Dr. Aaland provides a hands-on demonstration in Tioga.

Photo courtesy of the Tioga Tribune

agreed to purchase a kit for each participant.

"It really helped that we convinced our Board of Directors to finance the kits," said Uecker. "Every participant received a Stop the Bleed kit to take home with them."

Training the crowd ran smoothly, as people showed up in groups of 8-12 every half hour. The first half hour session was a presentation conducted by Dr. Aaland; then participants were given another half hour of practical learning on the just-learned techniques of applying a tourniquet, packing a wound and applying pressure. This part – the hands on technical training - was done by local, trained healthcare volunteers.

Photo courtesy of WRHS Foundation

Stop the Bleed class hosted by WRHS Foundation in Hettinger, ND.

It is Dr. Aaland's goal to train communities and make them self-sufficient to train others. So, this is where the multiplier effect comes into play. Now that Hettinger has trained participants and local healthcare volunteers, WRHS Foundation will once again be hosting another Stop the Bleed training event during the October KNDC Farm Home Show. "We know how to do this now that we learned from our champion, Dr. Aaland," said Uecker.

In addition to the West River service area, Dr. Aaland trained several other communities throughout North Dakota. "It's my goal to train 1,000 people each year, and so far, 300 have been trained."

Dr. Aaland is keeping her eye on the goal and continues to seek communities across North Dakota that can organize an event and raise money for the kits. This fall, the Linton Public School will be working with the North Dakota Chapter of the American College of Surgeons Committee on Trauma to train school staff and students on how to stop the bleeding. Training an entire school takes a community effort by banding together to teach, train and purchase Stop the Bleed kits. A kit to meet a school's capacity like Linton costs roughly $800.

According to Dr. Aaland, the kits are costly because some of the contents are expensive, but necessary, like the hemostatic gauze that causes blood to clot quickly. In addition to the hemostatic gauze, kits include items like tape, ace or compression bandages and tourniquets to tie off bleeding to an arm or leg.

"You can stop bleeding without a kit, but having the hemostatic gauze can make all the difference in a critical situation," said Dr. Aaland. "Part of the training is teaching people how to stop the bleeding without a kit, by simply applying pressure, and teaching participants to know its ok to touch the wound."

Dr. Aaland's passion to work with schools reaches back to the Sandy Hook school shooting. "They found that some children could have been saved if people on site were trained in basic bleeding control," explained Dr. Aaland. "During a shooting, schools are in lockdown so paramedics don't have access until the scene is safe."

Dr. Aaland says the goal for schools is to get as many local doctors, nurses, paramedics and others to train school staff in how to stop bleeding, and then have the staff – teachers and administrators - train middle and high school students.

Dr. Aaland admits that she could not do this without the support of the UND School of Medicine and Dr. Robert Sticca, Chairman, Program Director, and Professor in the Department of Surgery at the University of North Dakota School of Medicine and Health Sciences. The commitment from UND and Dr. Sticca to fix North Dakota's rural health care issues and solve the problem of delivering care to rural America is unsurpassed. This dedication allows fellow doctors, like Dr. Aaland and many other dedicated physicians, carry out the mission of continuously serving rural health care needs best.

HOW CAN YOU HELP

MAKE A DONATION TO HELP PURCHASE "STOP THE BLEED" KITS

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Congressional Corner

An Update from North Dakota's Congressional Delegation

Working to Implement the VA MISSION Act the Right Way to Provide Convenient, Quality Care for Veterans

By Senator John Hoeven

Earlier this year, the president signed into law the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act. This is bipartisan legislation that improves upon the Veterans Choice Program and consolidates all the Department of Veterans Affairs (VA) community care programs into one, new Veteran Community Care Program. This is all about ensuring our veterans can access convenient and quality health care, both at the VA and through non-federal providers in local communities. However, it isn't enough just to pass this bill. We need to ensure this is implemented in the right way and avoids the pitfalls of excessive bureaucracy. Doing so will ensure our veterans can access the care they need and the providers who serve them are reimbursed in a convenient and timely fashion.

That's why I am working with stakeholders and veterans in North Dakota to guide this bill's implementation, similar to our efforts with the Veterans Care Coordination initiative. This initiative helped to significantly reduce waiting times that veterans faced under the Veterans Choice Program and empowered local providers to work with my staff and the Fargo VA to resolve Health Net's outstanding payments. Now, we are bringing that same approach – applying the expertise of our high-quality staff at the Fargo VA and local Veteran Service Organizations, who work to serve our veterans everyday – to ensure this legislation achieves Congress' goal of improving veterans' access to health care and building stronger partnerships with local health care providers.

To this same end, I worked to include important measures in the bill to provide veterans with quality health care, closer to home. This includes key provisions from my **Veterans Access to Long Term Care and Health Services Act**, which will expand long-term care (LTC) options for veterans in their home communities. Currently, only about 20 percent of North Dakota nursing homes contract with the VA due to the agency's burdensome regulations and reporting requirements. The provisions we secured will allow the VA to enter into provider agreements with qualified health care and long-term care facilities, provide relief from expensive federal contracting requirements and enable more LTC providers to accept veteran patients.

Further, we **eliminated the arbitrary 30-day/40-mile rule**, which acted as a barrier to veterans receiving care through the Veterans Choice Program. This rule undermined veterans' ability to access care closer to home and often required them to travel long distances to receive health care. We've also expanded caregiver benefits to veterans of all eras. Previously, these benefits were only available to caregivers of post-9/11 veterans, and by opening up eligibility, we give the family and friends who care for our veterans the support they deserve.

At the end of the day, the VA MISSION Act is all about empowering veterans to use the health care benefits they earned, including accessing local providers when nearby VA facilities cannot provide the services. That means a higher quality of life for our veterans. But, our work isn't done. We will continue to strive to ensure this bill is properly implemented and that it reforms VA community care in the way that best serves our veterans.

Improving Access to Rural Health Care through Bipartisan Efforts

By Senator Heidi Heitkamp

Rural communities are the backbone of North Dakota, but they often face unique health care challenges due to their remote locations.

As co-chair of the Senate Rural Health Caucus and as the spouse of a family physician, I know that North Dakota's doctors, nurses, and community providers are key components of delivering high-quality, affordable health care in these towns and townships. That's why I've been working in the U.S. Senate for years to find bipartisan solutions that help them make health care more affordable and accessible for rural North Dakotans.

In February, my bipartisan bill to strengthen rural health care delivery systems passed out of a U.S. Senate committee. Introduced alongside U.S. Senator Pat Roberts (R-KS), my co-chair on the Senate Rural Health Caucus, our bill would allow State Offices of Rural Health to continue receiving the critical support they need through 2022 to bolster the rural health workforce and increase affordability of local clinics and hospitals.

And later that month, I pushed for several rural health care provisions in the budget deal signed into law, including a two-year extension of federal funding for Community Health Centers

and the National Health Service Corps – a particularly important program for increasing the rural primary care workforce. Additionally, the deal included a five-year extension of Medicare home health and rural ambulance add-on payments.

Another way to boost the quality of health care delivery in rural America is through telemedicine, which allows physicians to deliver care to children, seniors, and veterans in hard-to-reach communities. In May, I led a bipartisan group of 31 senators in urging the Federal Communications Commission (FCC) to strengthen the Rural Health Care (RHC) program, which connects rural health care providers to high-speed internet. Following our push, the FCC announced a proposal to increase funding for RHC – **the first increase for the program in over 20 years.**

But it's not just about making sure clinics are staffed or that ambulances are running. We are in the midst of a severe addiction and mental health crisis, and we can't ignore the trauma it creates among young people and the massive burdens it places on our health care providers. I've heard firsthand from the doctors and first responders who are on the front lines of this epidemic, and it's clear that childhood exposure to trauma – such as the opioid abuse of a parent – can lead to severe health and behavioral complications that can detrimentally impact children throughout their lives. In April, the Senate passed bipartisan, comprehensive legislation to combat opioid and other substance abuse, and the bill contains my provisions to address the ripple effects of the overdose epidemic on children, families, and communities.

We still have lots of work to do, and I'm committed to standing shoulder to shoulder with North Dakota physicians, especially in our rural areas. Thank you for all you do, and I'll keep fighting to improve and expand health care services across our state – regardless of zip code.

Moving Forward with a Stronger Electronic Health Records Policy

By Congressman Kevin Cramer

It's been 22 years since legislation to develop technology establishing a national health information system was included in the Health Insurance Portability and Accountability Act, known as HIPPA. Other laws have followed, including the Health Information Technology for Economic and Clinical Health Act (HITECH Act) in 2009.

While medical professionals have acknowledged the value of government involvement in initially developing and implementing health information technology, the burden has now become too onerous. When physicians say they spend more than half their time on electronic health records – time that could be better spent on patient care – these regulations are hindering instead of helping their ability to practice medicine.

Clearly, we need to work together to find a comprehensive and effective solution to lift this regulatory burden for physicians, patients, and health insurance providers.

The House Energy and Commerce Committee, of which I am a member, has broad jurisdiction for public health and research, health information technology and policies of the Department of Health and Human Services, National Institutes of Health and the Centers for Disease Control. This Committee has been at the epicenter of efforts in Congress and the Administration to streamline health care and related technology.

Here are some of the ways we have begun to find solutions.

In late 2016, medical reforms and initiatives in the 21st Century Cures Act passed Congress and became law. Included was a directive for government agencies to develop strategies, goals and recommendations to reduce regulatory and administrative burdens in electronic health records.

A bill to reduce the volume of future hardship requests for meeting electronic health record standards was included in the Bipartisan Budget Act of 2018, which became law in February. Legislation H.R. 3120 removes from the HITECH Act a requirement that the Secretary of Health and Human Services continue to make meaningful use standards more stringent over time. While this program was successful in driving adoption of electronic health records, many providers struggled to meet its requirements and sought hardship waivers. This new law eases a great regulatory burden for smaller healthcare providers.

Last October, President Trump issued an Executive Order to Promote Healthcare Choice and Competition and since then has begun work overhauling electronic medical record systems across the government. In March, the Centers for Medicare and Medicaid Services (CMS) began the MyHealthEData initiative to interconnect data from several federal systems and give patients more control and portability of their health data. CMS is also looking at how the burden of evaluation and management coding on physicians can be reduced.

In February, Health IT Now and the Bipartisan Policy Center issued a report on a study they conducted on the role of government in future health technology and digital health. The report concluded the federal government has a role in providing assurances of meeting core consumer protections and funding research to identify successful IT practices and standards.

This seems to be a practical policy direction to implement for the future of health care in America. As always, I welcome comments and feedback about the challenges of providing health care to North Dakotans, and how together we can shape a stronger future.

Contact Congressman Kevin Cramer here: *cramer.house.gov.*

PHYSICIAN AWARDS

Dr. Rupkumar Nagala Appointed to Serve on the Federation of State Medical Boards Audit Committee

The Federation of State Medical Boards (FSMB) Chair Dr. Patricia King appointed Rupkumar Nagala, MD, a family medicine physician with Sanford Health located in Oakes, to serve a one-year term on the FSMB's Audit Committee.

The Federation of State Medical Boards represents the 70 state medical and osteopathic regulatory boards—commonly referred to as state medical boards—within the United States, its territories and the District of Columbia.

It supports its member boards as they fulfill their mandate of protecting the public's health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals.

The Audit Committee reviews the audit of the corporation and the accompanying financial statements.

Congratulations to NDMA member Dr. Rupkumar Nagala!

Dr. Gary Ramage Receives 2018 Outstanding Rural Health Provider Award

Gary Ramage, MD is the 2018 recipient of the Outstanding Rural Health Provider Award. The award, presented at the Dakota Conference on Rural and Public Health, is presented to a healthcare provider, who practices in rural North Dakota, and is unselfishly committed to improving the health of their community and service area.

Dr. Gary Ramage provides care to nearly 95 percent of the Medicare patients from the McKenzie County area and has a record of keeping his elderly patients healthy. His credo is to treat everyone like family. Dr. Ramage is the chief of staff of McKenzie County Healthcare System and has served the community as ambulance service director, nursing home director, county and city health officer, and aviation medical examiner.

In addition, he is a clinical instructor for the Department of Family Medicine at the University of North Dakota School of Medicine & Health Sciences.

Congratulations to NDMA member Dr. Gary Ramage!

Dr. Michael Greenwood Receives Delhi Ophthalmological Society Award

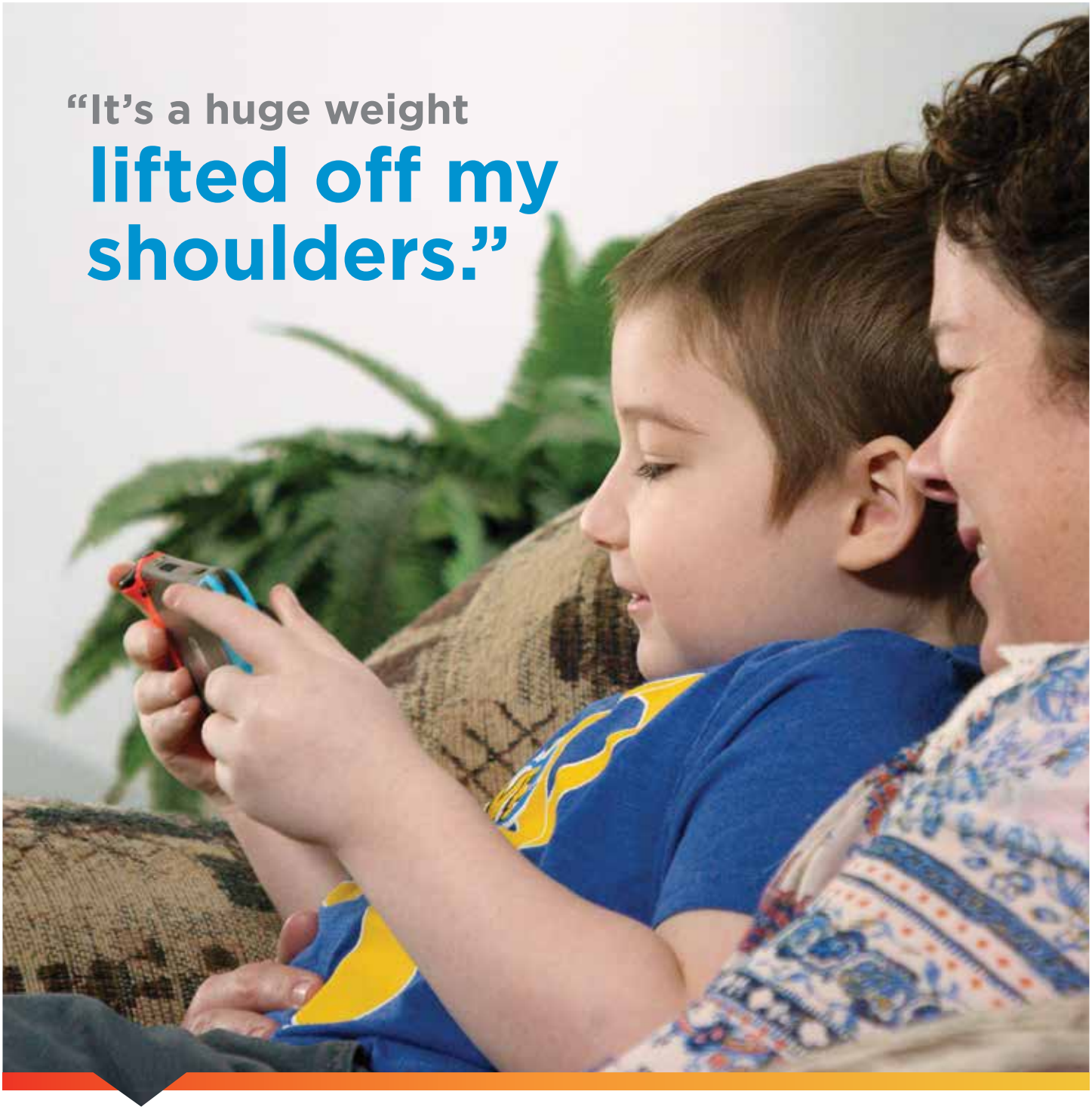
Michael Greenwood, MD, a physician with Vance Thompson Vision located in Fargo, is the recipient of the 2018 Delhi Ophthalmological Society Award for Academic Excellence and Outstanding Contribution.

Dr. Greenwood was invited to speak at the 69th Annual Conference of Delhi Ophthalmological Society held April 6-8, 2018 in New Delhi, India.

Dr. Greenwood's invitation to speak was recommended by the American Academy of Ophthalmology, where he presented and moderated a session on a highly-specialized area of ophthalmology - Complex Cataracts and Intraocular Lenses.

The opportunity allowed Dr. Greenwood to speak alongside colleagues from India (Ashvin Agarwal) and Australia (Bernardo Soares) where they shared new techniques on treating complex cataracts and intraocular lens implant procedures.

Congratulations to NDMA member Dr. Michael Greenwood!



Member advocates from Blue Cross Blue Shield of North Dakota. Inspired by fighters like the Jones family.

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Read Chase's story at
BCBSND.com/Chase

Noridian Mutual Insurance Company

Photo by Jackie Lorentz

Kristen Stenehjem, third year medical student at UND, completed a prestigious fellowship at Memorial Sloan Kettering Cancer Center in New York City.

A Family Tradition

By Jan Orvik, UND Today Writer

Kristen Stenehjem remembers hearing legendary stories about her great grandfather, the only family physician in McKenzie County during the Great Depression. He was known for his dedication to patients and for using a sleigh in the winter to reach patients during smallpox and flu outbreaks.

Four Stenehjem women have ties to UND SMHS.

Those stories and her hometown physician in Watford City inspired her to enter medical school. Today, four Stenehjem women – all cousins – are, or will be, graduates of the UND School of Medicine & Health Sciences.

Kristen Stenehjem is a third-year medical student who recently completed a prestigious fellowship at Memorial Sloan Kettering Cancer Center in New York City. Brynn Stenehjem is a second-year resident at Abbott Northwestern Hospital in Minneapolis. McKayla Schmitt (neé Stenehjem) recently completed her pediatric residency at the University of Minnesota Masonic Children's Hospital in Minneapolis. And Amy Stenehjem-Kelsch earned her medical degree from UND in 2000 and owns a consulting business helping people navigate the health care system.

Besides their names and affinity for medicine, they share a great appreciation for the UND School of Medicine & Health Sciences.

Medical student

Kristen Stenehjem, who grew up in Watford City, credits UND's patient-centered learning curriculum for her fellowship at Memorial Sloan Kettering Cancer Center.

"I had heard that the Sloan Kettering internships were very competitive," Kristen said. "I applied but didn't tell my family in case I didn't get in." She was the only student from the Midwest who was accepted for one of 20 spots.

"Everyone else was from Ivy League schools and the East Coast," she said. "I proved myself by working harder and going in early and staying late. It's that North Dakota work ethic." It paid off: Kristen was asked back next summer.

She worked in pediatric oncology, working with adults who had childhood leukemia and looking at the long-term effects they experienced.

"We found that survivors are more likely to be obese or overweight, and to develop cardiometabolic diseases, including diabetes," Kristen said. "We wanted to find out why, and to implement diet and exercise programs to help survivors lose weight and prevent diseases. It was a great experience."

"I had worked with patients before, while many of the other medical students hadn't," Kristen said. "The training in patient-centered learning at UND really helped. We study patients, not just books. We look at how patients are affected physically, mentally, and we meet with patients. This really helped me with my internship."

Second-year resident

Brynn Stenehjem also credits the patient-centered learning curriculum for her great experience as a resident at Abbott Northwestern Hospital in Minneapolis.

"UND absolutely prepared me well," said Brynn, who grew up in Ulen, Minn., about 40 miles from Fargo. "When I interviewed for my residency, I could show how much experience I had working in teams and with hands-on patient care. I had more experience than a lot of students from big-name medical schools."

"The patient-centered learning curriculum paid off," Brynn said.

"I realized later how much those communication-based third and fourth years helped me get to know patients. That connection with people is a North Dakota thing that carries into medicine."

Practicing physician

Communication with patients and their families is so rewarding, said McKayla Schmitt, who recently completed her residency at the University of Minnesota in Minneapolis.

McKayla grew up in Bismarck and Fargo, and earned her undergraduate degree in biology from UND before attending medical school. She said her UND education prepared her well for her residency, and her third- and fourth-year clinicals at the Minot Center for Family Medicine, part of the UND SMHS.

"I love working with kids," said McKayla. "It's a lot of fun. And it's so rewarding to have families reach out to me after I've taken care of their children. Hearing about the impact I may have had is rewarding."

Alumnus

"UND was my first choice," said Amy Stenehjem-Kelsch, who graduated from UNDSMHS in 2000 and from her residency in 2004 from the University of Missouri at Columbia, where she was chief resident. She grew up in Williston.

"UND medical school was a fantastic experience, with superb training," said Amy. "I felt as well trained, if not better, than residents all over the U.S."

After medical residency, Amy and her husband, Chad Kelsch, a UND Law alum, moved to the Twin Cities where she worked as a staff physician at Park Nicollet Clinic and later Physicians' Diagnostics & Rehabilitation.

I want to find ways to help rural communities get better access to care.
— Kristen Stenehjem

After being diagnosed with a chronic health issue, she was unable to practice medicine and began working as a consultant who helps people with chronic health issues navigate the health care system.

"I miss practicing, but can work from home and still interact with patients," she said.

Carrying the tradition

In their own ways, the Stenehjems are carrying on a new tradition.

And the School of Medicine & Health Sciences has given them the tools to do so.

"North Dakota faces unique medical challenges," said Kristen. For example, Watford City has just one hometown doctor and a small hospital. I want to find ways to help rural communities get better access to care."

Her experience at Sloan Kettering could help her do that.

"The most rewarding experience at Sloan Kettering was working with physicians who are the best in their fields. It was very collaborative, very focused on patients. That's the type of environment I want to work in. It was what we are being taught in medical school: to focus on the patient, not the disease. UND is preparing physicians well."

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MANAGING NORTH DAKOTA'S Prescription Drug Monitoring Program

Over the past 10 years, the North Dakota Board of Pharmacy, in collaboration with the ND Medical Association and other stakeholders, has been diligently working on improving and developing the state's Prescription Drug Monitoring Program (PDMP) to provide information to the growing opioid problem. The North Dakota PDMP is connected with 35 states and continues to enhance current connections and expand to other states as they become available. The North Dakota PDMP currently tracks schedule II-V controlled substances and gabapentin, which was added in August 2017.

The purpose of the PDMP is to identify individuals involved in diversion or abuse of controlled substances and to improve patient therapy. This in turn will protect public safety and improve public health.

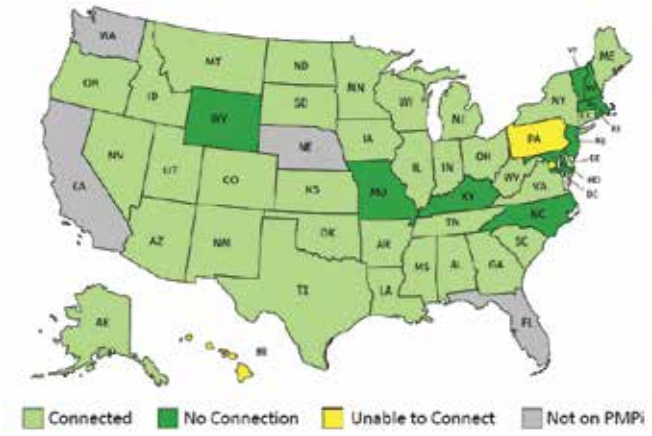
North Dakota's program sends out proactive alerts on patient's exceeding a daily active MME level and concurrent prescribing of opioid and benzodiazepine prescriptions reflecting the CDC's guidelines for prescribing opioids. It also sends out alerts when a patient exceeds a threshold of a designated number of prescribers and dispensers per the Advisory Council's suggestion.

As many of you may already know, the ND Board of Medicine and other states' prescriber boards issued mandatory use/registration regulations which went into effect on January 1st, 2018. This had a dramatic impact on the utilization of the program. There was an 81% increase in the number of registrations for Doctors and Physician Assistants and a 31% increase in prescriber delegate (nursing and assistive staff) registrations. The utilization rate for physicians went from 42% by the fourth quarter of 2017 to 59% by the end of the first quarter in 2018. This was the largest increase since the inception of the program and electronic registrations. Prescriber requests increased by 21% from 2016 to 2017 with an estimated increase of around 30% for 2017 to 2018.

Reports are published quarterly on additional statistical information about the PDMP and can be found at: www.nodakpharmacy.com/PDMP-index.asp. Of particular interest may be the county comparison of both all reportable prescriptions and breakdown of opioid prescriptions.

In addition to PDMP, there are many other resources for prescribers to access when treating patients with opioids. MyTOPCARE provides risk assessment tools, resources when starting, continuing, and stopping an opioid, and even information for patients. The Centers for Disease Control and Prevention published guidelines in 2016 for prescribing opioids for chronic pain and provides an online training series for providers.

We invite you to contact the ND Board of Pharmacy for any PDMP assistance or questions you may have by emailing *pdmp@ndboard.pharmacy.*



Submitted by

Kathy Zahn
Program Administrator
Prescription Drug Monitoring Program
North Dakota State Board of Pharmacy

Kati Mastel
Pharm.D. Candidate 2019
North Dakota State University

No Longer Lost in Translation

Improved Radiology Reporting Aims to Reduce Diagnostic and Follow-up System Errors

By Anne Geske
Managing Editor, *Brink*

Getting the diagnosis right—what could be more important in assessing a patient's symptoms? Imaging tests such as X-rays, CT scans, MRIs, ultrasounds and mammograms are essential tests within the diagnostic toolbox. So, it follows that any communication between the radiologists interpreting these exams and the clinicians who order them is essential. And yet, it's not so simple.

The communication challenge

Radiology is a complex specialty, and radiologists use intricate language in test reports read by the medical professionals who order them. Because communication between radiologists and clinicians usually takes place within written reports and the electronic health record (EHR)—not in person or via phone—the potential for error is significant. MMIC found that the misinterpretation of tests and results, including radiologist-to-clinician communication, is a contributing factor in 27 percent of malpractice allegations.[1] More effective communication between radiologists and ordering clinicians may have made a difference.

The reference process

In 2015, the American College of Radiology supported a process radiologists could use when communicating to referring clinicians through the radiology report: a standard management recommendation suggesting next steps for evaluation, along with a reference supporting that recommendation.

Sue A. Crook, MD, FACR, is a radiologist with Suburban Radiologic Consultants in Bloomington, MN, whose staff works with large Twin Cities health systems that have been rolling out the "reference process," as it's referred to in short, since 2015. "We help clinicians know what the next step is," says Dr. Crook. "Following the impression of our report, we suggest further follow-up and what the evidence-based reference is for that."

The reference process is a way for radiologists to uniformly use consensus guidelines in their recommendations.

Reducing human error

Without such a process, the referring clinician interprets the complex terminology in the radiologist report and makes their own determination for next steps. And because clinicians are human, perceptions and second-guessing may come into play. Radiologists have sometimes had to strike a balance between what might be seen as over-diagnosing (making sure results aren't dismissed that point to further work-up) and under-diagnosing, in which more serious issues might fall through the cracks. "In the past, there have been lawsuits where a radiologist interpreted results correctly," Dr. Crook explains, "but the referring physician thinks the radiologist overcalled it and decides to dismiss the issue. With this new process, I can say in my report, 'I'm worried this patient may have cancer. We need to do the next test, and here is the evidence-based reference.'"

The reference process helps ensure that patients who need further evaluation get it. This relatively new patient-safety process may soon become a common best practice. Its implementation is recognized as a cutting-edge way to ensure that communication between radiologists and busy clinicians doesn't fail. "Along with physicians, we have PAs and NPs referring patients to us," Dr. Crook says. "They're busy, and when they see the management recommendation, it pops out. It's something they can pay attention to, to make sure that they *understand* the report."

Culture shift

In Dr. Crook's experience, health care culture is becoming more collaborative. More radiology groups are using management guidelines to prevent diagnostic error, prevent follow-up system failures and improve communication with clinicians.

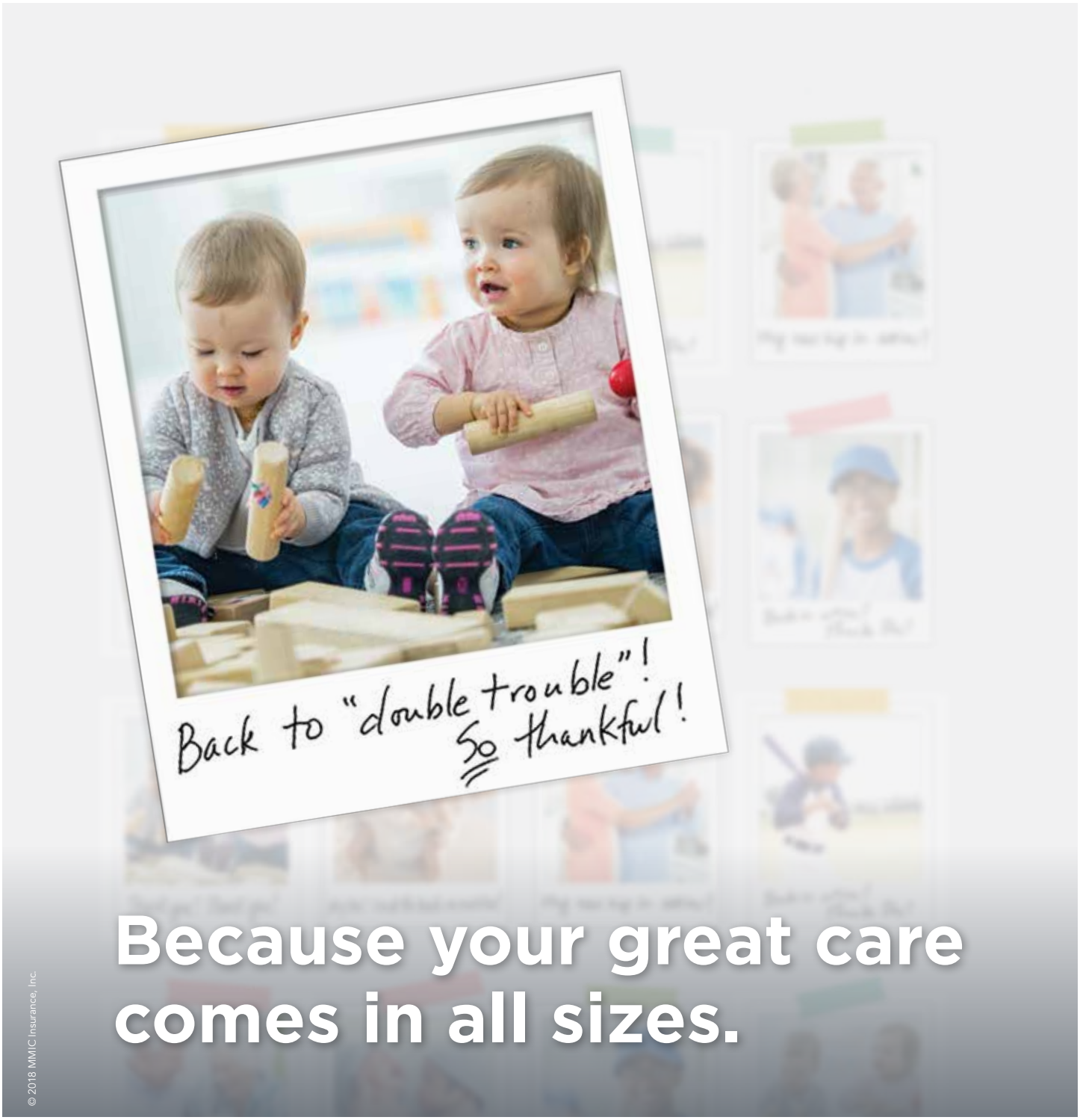
As medicine gets more complicated, medical professionals are realizing they can't do it all. "As we get more collaborative, physicians are happy for the help," Dr. Crook says. "Health care is becoming more patient-centered and more of a team effort."

The reference process helps ensure that patients who need further evaluation get it.

Reference

1. Brink, 2017 Spring Issue. bit.ly/2lWAWLH Accessed July 6, 2018.

This article originally appeared in the Spring/Summer 2018 issue of *Brink*® magazine, published by Constellation. MMIC is a member of Constellation, a collective of MPL insurance and partner companies offering solutions that are good for care teams and good for business. To learn more, visit *MMICgroup.com*.



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Sign up to participate for one day or choose as many days as you wish. To learn more or to sign up contact NDMA at 701-223-9475 or get this done online by logging onto *ndmed.org.*