



# Physician

September 2013

NDMA Annual Meeting

AMA Annual Meeting Recap

DocbookMD

EHR Discussion

Financial Health

*Medicine in Motion:  
Information Technology  
and Health Care Reform*

**NDMA**  
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Est. 1887

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

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# In this Issue



Report from our AMA Delegate ..... 10



Health Information Technology ..... 18

Physician Advocate ..... 3    NDMA Annual Meeting ..... 13

NDMA in Action..... 5    DocbookMD ..... 22

News from UND SMHS..... 8    Financial Health ..... 26

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### On the cover

Dr. A. Michael Booth hard at work at St. Alexius Medical Center in Bismarck, North Dakota. Dr. Booth has served on the NDMA Council for ten years. He is the current president of NDMA.



# Physician Advocate

Baseball, medicine, and the NDMA:  
Patience and perseverance really do matter

**M**id-summer 2013 in North Dakota: In Minnesota, the Twins are well on their way to their third consecutive losing season. In Bismarck, my hospital's staff seems to be getting younger and younger. Practicing team-based medicine has become an exercise in coaching high school sports. Participating in my hospital's administration has become ever more demanding. But, this is not the time to give it up. Too much is at stake.

Medicine in general, and organized medicine in particular, is experiencing a quiet but breathtaking transition. North Dakota is very much on the forefront of this transition. Over the next few years the full force of the Affordable Care Act (ACA) will be felt. We have heard the promises of better coverage for most Americans, with fewer uninsured patients and more consistent insurance coverage. At the same time, our federal government is drowning in a sea of red ink. Our economy beyond the borders of the Bakken remains in the doldrums. Whether or not we can afford the ACA remains an open question. More to the point, with the government increasingly in control of our revenue, the question is not whether we can afford it, but how big will the cuts be? And how will the push for "quality" impact our finances?

In spite of this, we are practicing some of the smartest, most efficient medicine ever. Over the past two decades, our clinics and hospitals have transformed themselves from a patchwork of independent enterprises into systems of integrated networks where planning and investment are being taken seriously and pursued aggressively. One system now controls nearly 40% of the state's

beds and physicians and appears poised to push its expansion even further. Not so long ago, our NDMA was worried about a single payer system. Are we now facing a future with a single provider?

There was a time when it seemed the New York Yankees would never be beaten. They had a seemingly infinite reserve of cash with which to sign the best free agents. The truth is that they got lucky with some guys like Derek Jeter, Mariano Rivera, Andy Petite, A-Rod, and Roger Clemens. For every one of those guys, there were five or six others who were a bust. Remember Chuck Knoblauch? Remember the (California) (Anaheim) Los Angeles Angels? The teams who got rid of those inflated contracts were able to save their money and invest in a new generation of players; players who are now coming into



A. Michael Booth, MD

their own in someplace other than the Big Apple (Go Oakland!). Patience and perseverance does pay off in baseball.

For the same reason, I doubt we will be worried too much about a single provider in North Dakota, or a concentration of mega-systems. The other 60% already understand what they must do to survive. I'm sure the big guys will continue to focus on making theirs a responsible, high quality operation as well. Their



Dr. Booth at Target Field in Minneapolis, MN, on July 4, 2013, with his mother, Pat Booth.

Continued from previous page...

management is much smarter than the Steinbrenner family. The economics of medicine, regardless of any benefactors with deep pockets, won't allow anything other than high-quality, high-productivity performance in the years to come.

As physicians, this gives us an unprecedented (dare I say epic?) opportunity to do wonders for our patients, provided we understand and exploit the power and quality our integrated networks can bring to bear. In my own hospital, I am already seeing the benefits of an in-house hospital medical staff improving our results and making life livable for our physicians. Even though our EHRs have a long ways to go, already my job has become much easier when I'm asked to consult on a new patient. Gone are those seemingly endless hours spent at the film desk in the X-ray department. I no longer have to fumble through mountains of paper charts in search of handwritten notes to decipher. I've also had to input the number for my hospital lab to my contacts list in my cell phone. It will only get better. The key, however, is to make sure that we as physicians stay intimately involved in our organizations to keep the improvements coming. That couldn't have been done the way we were organized 20 years ago.

If you've seen the movie "Money Ball" or preferably read the book, you will have been introduced to the concept of sabermetrics. Started by a baseball statistician named Bill James, and developed by the Society for American Baseball Research, this concept of statistical analysis of baseball players' performance has revolutionized the way players are evaluated and managed. It's the reason small market clubs like Oakland, and some not so small market clubs like Boston, have done so well in recent years. Medicine, of course, has traditionally relied heavily on statistics for its clinical research. However, with the increasing availability of sophisticated programming solutions at the community level, it is just a matter of time before the sabermetrics are adapted to evaluate patient care. It won't just be our hospitals and clinics

that undergo this analysis: it will be us as physicians who get crunched in the computers. We have all seen the first generation of "quality measures" on government websites such as Health Compare. They are pretty crude, but beware: those measures will get more sophisticated and applied to more than just basic primary care parameters.

As physicians, we need to be patient with the changes around us. We need to persevere in our efforts to make our practices ever more efficient and effective. We need to be patient with our new partners, take the time to mentor them and develop them into the skilled, highly effective players that our teams need. That, of course, includes the administrators who are responsible for the day-to-day management of our systems. And with respect to sabermetrics, we need to become better analysts of our own work.

For organized medicine, it means making certain that our non-physician

team members understand the value of a strong state medical association that provides a forum for our physician leaders to come together and share their research and experience as they strive to bring the benefits of modern medicine to our patients. We cannot allow them to compromise this organization, or any other such organization that provides a similar forum for our health care professionals. We need to be able to speak when necessary as a unified voice when events around us threaten to compromise our ability to care for our patients. Now, more than ever, we need to network between our organizations to make our system shine. The NDMA has been around now for over 125 years. Never in existence has it compromised any clinic's competitive edge. It has only improved us all. That will continue to be the case in the future.

I look forward to seeing you at the annual meeting in Fargo in October!

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## Summer Congressional Action Moves Toward SGR Repeal

On July 31, 2013, the House Energy and Commerce Committee unanimously approved bipartisan legislation that would repeal the current Medicare physician payment system and replace it with one based on quality of care measures and new care models. The legislation would repeal the Sustainable Growth Rate (SGR) formula in Medicare's current system and create a fee-for-service system in which providers report quality measures. Physicians also would have the ability to opt-out of the fee for service system and participate in new ways of delivering care, such as medical homes, bundled payment or episode-of-care concept.

Under the proposal, during the five year phase-in period, physicians would receive a 0.5 percent annual increase per year. During this period, physician groups—in coordination with the Department of Health and Human Services and medical standards-setting organizations—would play a central role in designing quality metrics that would be implemented in 2019.

Beginning in 2019, physician Medicare payments would include adjustments up or down, depending on how well their services met the new quality guidelines. Physicians receiving the highest quality scores would receive a 1 percent payment increase over standard Medicare rates; physicians with quality scores in the midrange would receive no increase; and physicians in the lower range would receive a 1 percent payment reduction. Providers could also choose to participate in demonstration programs featuring alternative payment models aimed at coordinating care and improving quality of care for patients.

This is good news for a system that had many problems from its very inception. The SGR was included the Balanced Budget Act of 1997 to control Medicare spending by linking it to the nation's economic growth rate. Since then, Medicare spending has outpaced the nation's economic growth, causing lawmakers to pass a "doc fix" annually for the past decade to cancel resulting payment cuts.

Although it is a step in the right direction, there is considerable work to be done. Lawmakers have not identified ways to pay for the legislation, which could make the process of drafting a final bill more complicated. According to the Congressional Budget Office (CBO) freezing physicians' Medicare reimbursement and preventing SGR-related cuts for 10 years would cost \$139 billion.

That is about \$100 billion less than previously estimated, and as a result, lawmakers and physician groups say this year provides the opportunity



Courtney M. Koebele, JD

to permanently fix the system at a lower cost. Under the present system, physicians' Medicare reimbursement will be reduced by 24.4 percent in January 2014, unless Congress acts.

Due to its high price tag, a permanent fix has eluded Congress. Even with the lower estimate, funding the legislation represents perhaps its greatest challenge to advancing. House Republicans have decided to first address the policy involved in replacing the SGR, choosing to address funding the measure later so as to not break momentum in passing the legislation.

Funding the bill will be contentious. Democrats will withdraw support if costs are shifted to program beneficiaries. The SGR repeal also could be rolled into a larger budget and tax package that perhaps would be raised by Congress and the White House later this year, which could allow lawmakers to use unrelated health care provisions to offset the cost.

Following the August Congressional recess, two additional committees, the House Ways and Means Committee and the Senate Finance Committee, will work to produce their own versions of the legislation, each with the goal of repealing the SGR, focusing on quality over volume,

**NDMA, along with all of organized medicine, will continue to work with Congress this year to achieve the best Medicare system for patients and physicians... Now is the time to move toward a Medicare program that supports physicians for providing high-quality, patient-centered health care.**



*Continued from previous page...*

and making alternative payment and delivery models available. Later in the year, these measures will likely be combined and brought to a vote on the House and Senate floors.

NDMA, along with all of organized medicine, will continue to work with Congress this year to achieve the best Medicare system for patients and physicians. It is important that we encourage lawmakers to continue working in a bipartisan manner and keep the momentum towards repealing the SGR and designing a new Medicare physician payment system. Now is the time to move toward a Medicare program that supports physicians for providing high-quality, patient-centered health care.

### Annual Meeting

NDMA's annual meeting is being held October 3-4, 2013, at the Fargo Ramada Plaza Suites. We are thrilled to announce that AMA Board of Trustees member Sue Bailey will be our keynote speaker to kick off the meeting. Dr. Bailey was re-elected to the American Medical Association (AMA) Board of Trustees in June 2012.

A tenacious advocate for physicians and patients, Dr. Bailey has held numerous positions for the AMA. She was chair of the AMA Council on Medical Education, chair of the Texas delegation to the AMA, and served as the AMA representative to the Assembly of the American Board of Medical Specialties.

Our CME presentation is focusing on payments and payment reform. Dr. Tim Bartholow, Chief Medical Officer of the Wisconsin Medical Society, will be speaking with regard to helping physicians be more aware of how their clinical decisions drive costs, understanding overall health care expenses in the national economy, and finally, exploring the financial impact of coordination of care as a substantial solution to health care. In addition, Dr. Mark Levine, Chief Medical Officer for CMS Region VIII, will be updating NDMA on the Center for Innovation and the opportunities available to NDMA physicians. The final hour is a panel made up of representatives from Blue Cross Blue Shield of North Dakota, Sanford Health Plan, and North Dakota Medicaid discussing updates and the impact of health care reform.

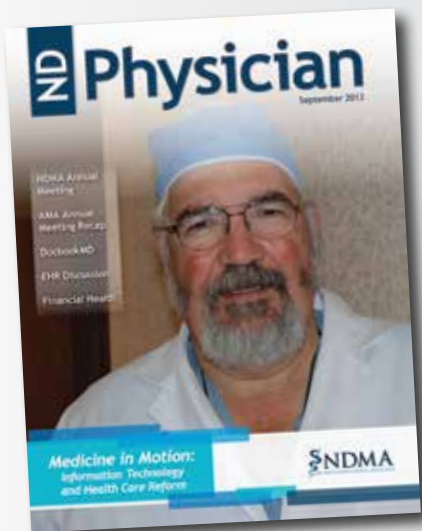
### President Michael Booth

I would like to thank President Mike Booth, pictured on the cover of this issue, for his exemplary service to the North Dakota Medical Association these past 2 years. Dr. Booth is a Bismarck cardiac surgeon who worked tirelessly on behalf of NDMA on numerous issues affecting medicine throughout his term.

President Booth represented NDMA during trips to the local district meetings, many trips to Washington DC, AMA meetings, White Sox games, and more than a few legislative hearings. Among many issues during this past legislative session, Dr. Booth had a large influence in the vulnerable adult law being passed in North Dakota. North Dakota was one of a handful of states that did not have mandatory reporting of suspected vulnerable adult abuse. Dr. Booth testified in both the House and Senate subcommittees on behalf of NDMA and the bill passed with bipartisan support.

From Frontier States to interference with the patient-physician relationship, Dr. Booth was an enormous influence during his tenure as President. Thank you Dr. Booth! 🙏

## In the Next Issue



### The Value of Professional Organizations

Our December issue of ND Physician will highlight several topical areas, including the value of belonging to and participating in a professional organization. We will look at local specialty societies as well as large national associations.

### We need your input!

If you'd like to know more about a specific topic or can contribute to the content of ND Physician, contact Katie Cashman, editor, at 701-223-9475 or [katie@ndmed.com](mailto:katie@ndmed.com).

# Bank of North Dakota announces Student Loan assistance for North Dakota physicians

During the 63rd Legislative Session, legislators passed a bill directing Bank of North Dakota (BND) to expand its Student Loan Consolidation Program. Beginning August 1, 2013, physicians working and living in North Dakota cities, with a population of 4,500 or less, may consolidate their State, Federal, and Alternative Education Loans into a DEAL Consolidation Loan.

The DEAL Consolidation Loan, which is part of North Dakota's State-Sponsored Student Loan Program, is currently available to North Dakota residents. The legislation allows physicians to include their Federal Loans in the Consolidation Loan, resulting in lower interest rates and extended repayment terms for many applicants. Participants in the BND program appreciate the convenience of having all their student loans at one place with local service they can count on.

## FOR MORE INFORMATION

Shirley Glass, Student Loan Manager 701-328-5792  
Tom Ternes, New Loans Supervisor 701-328-5658



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# A Big Agenda

## News from the Dean of the UND SMHS

The UND School of Medicine and Health Sciences' new academic year began on July 1, and I'd like to provide a brief update on the four major initiatives that the SMHS is undertaking this year: planning for the new building; preparing for the School's reaccreditation visit by the Liaison Committee on Medical Education (LCME) that will occur in March of 2014; consolidation of the four basic science departments into a single department under one chair, Dr. Malak Kotb; and expansion of class sizes to help meet the health care needs of North Dakota as part of the Health Care Workforce Initiative. Undertaking any one of these tasks would be a major effort; doing all four at the same time will tax our faculty, staff, and students. But they are all interrelated projects, so there will be some economies of scale and scope. Nevertheless, given the relatively small size of our School, successfully completing all four at the same time is going to be a challenge, but one that I know we are capable of meeting—as long as we continue to work together effectively and focus on the common good.

We recently completed a "Boot Camp" of initial planning for the new building. Planning for the building continues in full swing, and over 200 people from the School and across campus have been involved in a variety of subcommittee activities to help define the guidelines for the new facility. It has been an extremely labor-intensive effort, but a whole slew of great ideas have been

forthcoming. As is usually the case in such construction projects, the requests for space have exceeded our budget, so hard decisions have been made, but the robust input that has occurred is vital to an optimal eventual outcome.

Following careful analysis and deliberation, a site has been selected for the new home of the UND School of Medicine and Health Sciences. The location is an 8.25-acre plot of land on the southwest corner of the intersection of North Columbia Road and Gateway Drive in Grand Forks. Several potential sites on the UND campus were considered and evaluated by the Site Recommendation Committee, based on factors such as parking availability, pedestrian access, size of buildable area, proximity to steam/gas sources, etc. A public forum about the building project was held in June, and public input was invited. The site decision was announced by UND President Robert Kelley in July.

Preparations for the LCME reaccreditation visit in March 2014 are progressing, probably with about 90 percent of the work done on the institutional and medical student self-studies. The remaining 10 percent of the report always takes proportionally longer to complete, but we should be largely done with the body of the work by the time you are reading this report.

The consolidation of the basic science departments is proceeding. Dr. Kotb,



Joshua Wynne, MD, MBA, MPH

the founding chair of the combined basic science department, is here and hard at work. I have been impressed by how supportive the faculty and staff members have been during this time of transition, which predictably is stressful and unsettling. Nevertheless, once the consolidation is completed, there will be substantial gains in terms of enhanced collaboration and interaction across disciplines.

Efforts continue as we gear up for class size expansion. We are exploring various options for expanding clinical opportunities for medical students during their clinical years (Years Three and Four). Fortunately, we have another year to plan before the first wave of eight additional medical students hits the third year, and three years before the full cadre of 16 additional students enters the clinical years. One exciting option for expansion is the Minot Integrated Longitudinal Experience (MILE), which is growing from four to six students.


Finally, I'd like to offer some comments regarding my take on the status of the electronic health record (EHR), particularly given that focus in this issue of ND Physician. If the EHR were a student taking a course with me, I'd give the EHR a grade of "incomplete" and would comment that "...this student has great potential but hasn't yet lived up to it." Such was the conclusion of a report in the prestigious journal Health Affairs earlier this year. The authors of the report attributed the disappointing performance to date of the EHR to incomplete adoption of the technology, limited interconnectivity of different systems, lack of user-friendliness, and

**Planning for the building continues in full swing, and over 200 people from the School and across campus have been involved in a variety of subcommittee activities to help define the guidelines for the new facility.**



our failure to adequately redesign processes of care to fully capitalize on the opportunities offered by the EHR. Published studies are generally supportive of the positive effect of the EHR on quality and safety, although most of the purported gains have been modest. The net impact to date on productivity and cost is even more equivocal; despite the nearly \$30 billion investment of the federal government through the meaningful use program, there are limited data to demonstrate a beneficial effect. One study found that the average physician adopting the EHR would lose almost \$44,000 over five years, and only about a quarter of practices would achieve a positive return on investment at the end of that time. Parenthetically, one of our UND medical students did a summer research project looking at provider preferences and opinions regarding the EHR; I'll share his findings with you in the next column.

**Efforts continue as we gear up for class size expansion. We are exploring various options for expanding clinical opportunities for medical students during their clinical years (Years Three and Four)...One exciting option for expansion is the Minot Integrated Longitudinal Experience (MILE), which is growing from four to six students.**

So just how do we as an industry move this process forward so we can reap greater benefits for our patients and our health care delivery system? The vendors and hospital systems need to make our EHRs more user-friendly and interoperable, so they communicate more easily with each other. The systems also need to be easy to access by our patients. And you and I need to work on our care delivery processes so that they optimize the value that the EHR can bring to our clinical practices. That won't be easy until we get better reimbursement models that favor quality over quantity, but we need to continue and expand the effort. Only by doing so will we change the grade of the EHR from "incomplete" to "satisfactory." Who knows? Maybe the EHR will eventually earn "honors"! 



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# National Issues

## A Report from Our AMA Delegate

In addition to the policy highlights detailed here, I am happy to report the victory of Dr. Maya Babu as an AMA Board of Trustees member. North Dakota supported Babu's campaign, along with the rest of the North Central Medical Caucus states (IA, NE, ND, SD, MN, and WI). It is great to have North Central represented on the national level!

Members of the American Medical Association (AMA) House of Delegates adopted a broad spectrum of headline-grabbing policies during the annual meeting June 15-19, 2013, in Chicago, IL.

We were fortunate to have the voice of North Dakota medicine represented so well. Shari Orser, M.D., Bismarck, AMA alternate delegate; Mike Booth, M.D., Bismarck, NDMA president; Steve Strinden, M.D., Fargo, NDMA vice president, and Courtney Koebele, NDMA executive director, joined me at the meeting.



From left: Robert Beattie, MD; Courtney Koebele, JD; A. Michael Booth, MD; Shari Orser, MD; and Steve Strinden, MD

### Policies Adopted at the AMA 2013 House of Delegates

The AMA adopted the following policies at its House of Delegates meeting in June 2013:

#### Opposition to Genetic Discrimination

This policy strongly opposes discrimination based on an individual's genetic information. The Genetic

Information Non-discrimination Act (GINA) was intended to protect individuals from genetic discrimination by health insurers and employers, but GINA did not address a number of areas in which genetic discrimination may still occur, and some people are not protected by GINA's provisions. The newly adopted policy supports legislation that would provide robust and comprehensive protections against genetic discrimination and misuse of genetic information.

#### Support of Public Access to Genetic Data

This policy encourages companies, laboratories, researchers, and providers to publicly share data on genetic variants and the clinical significance of those variants through a system that assures patient and provider privacy.

#### Pharmacy Compounding Safety

Traditional pharmacy compounding involves the act of combining, mixing, or altering ingredients to prepare a customized medication for an individual patient. However, the compounding industry has evolved over the past 20 years to include high capacity, industrialized practices involving batch production. The AMA adopted new policy recommending that traditional compounding pharmacies be subject to state board of pharmacy oversight. It also supports FDA oversight and regulation of facilities that compound sterile drug products without receiving a prescription order prior to compounding and introducing these drugs into interstate commerce.

#### Opposition to the Lifetime Ban on Blood Donations for Gay Men

This policy opposes the FDA's current lifetime ban on blood donations from men who have sex with men. The policy also expresses support for the use of rational, scientifically-based deferral periods that are fairly and consistently applied to blood donors.



Robert Beattie, MD

#### HIV Treatment as Prevention

Recent studies have confirmed that effective antiretroviral therapy can reduce HIV transmission by up to 96 percent. Previously, antiretroviral therapy for infected persons was delayed for years until CD4 cell counts dropped significantly and transmission occurred. Although new NIH guidelines recommend immediate antiviral treatment, these guideline changes have not been widely publicized to physicians. New policy adopted by the AMA supports programs to raise physician awareness of early treatment and "treatment as prevention" and the need to link newly positive persons to clinical care and partner services.

#### Obesity as a Disease

This new policy recognizes obesity as a disease requiring a range of medical interventions to advance obesity treatment and prevention.

#### Banning Marketing of Energy Drinks to Kids

Stimulant drinks have surged in popularity in recent years, especially among high school and college students, and health advocates are concerned about the use of these drinks among adolescents due to excessive amounts of caffeine. The FDA is continuing to investigate reports of illness, injury, or death of people who drank products marketed as "energy drinks" or "energy shots." The AMA adopted policy supporting a ban of the marketing of high stimulant/caffeine drinks to adolescents under the age of 18.

#### Health Risks of Sitting

The AMA adopted policy recognizing potential risks of prolonged sitting and encouraging employers, employees, and others to make available alternatives to sitting, such as standing work stations and isometric balls.

## Permitting Sunscreen in Schools

Laws in a majority of U.S. states do not permit students to carry over-the-counter medication in schools without a note from a physician. Sunscreen is considered an over-the-counter medication because it is regulated by the FDA. To prevent sunburns and skin cancer, the AMA adopted policy that supports the exemption of sunscreen from over-the-counter medication possession bans in schools and encourages all schools to allow students to possess sunscreen at school without restriction.

## Exam Room Computing and Patient-Physician Interactions

This new AMA policy asks the AMA to provide physicians resources for effectively using computers and electronic health records (EHRs) in patient-physician interactions and encourages physicians to incorporate questions regarding use of computers and EHRs in patient-satisfaction surveys to provide feedback on how their patients experience the use of computers in the examination room.

## Delivery of Care and Financing Reform for Medicare and Medicaid Dually Eligible Patients

In 2011, approximately \$300 billion was spent by the federal government and states for individuals who qualify for both Medicare and Medicaid. New AMA policy establishes principles for reforming the delivery of care for this population, including customizing benefits for patients and ensuring that care coordination



Dr. Booth with former Surgeon General Regina Benjamin.

demonstration programs do not interfere with the patient-physician relationship.

## Oncofertility and Fertility Preservation Treatment

New AMA policy supports coverage by all insurance providers of fertility preservation therapies for patients requiring cancer treatments that may result in infertility. Approximately 70,000 adolescents and young adults between the ages of 15 and 39 will be diagnosed with cancer this year, and fertility preservation therapy should be an essential part of the management of their cancer. Insurers do not routinely cover payments for fertility preservation treatment.

## Gay and Lesbian Medical Association Welcomed to the AMA Policy-Making Body

The Gay and Lesbian Medical Association (GLMA) was admitted to the House of Delegates - the AMA's policy-making body. Physicians and medical students unanimously voted to accept

GLMA's application for representation in the House of Delegates. GLMA's delegation joins the 187 medical societies with representatives in the House of Delegates, improving its role as the nation's broadest representational forum of physicians and medical students, dedicated to guiding the AMA and advancing the health of the nation.

## Reducing Medical Student Loan Interest Rates

Medical student debt has a significant and lasting effect on physicians and physicians-in-training, playing a major role in decisions relating to career path, specialty choice, and practice arrangements. To help address rising medical student debt, the AMA adopted policy to work with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program.

## Eligibility of Sugar-Sweetened Beverages for SNAP

Millions of Americans from low-income households receive assistance from the Supplemental Nutrition Assistance Program (SNAP). Studies have shown that sugar-sweetened beverages account for 58 percent of beverages purchased under SNAP. Consumption of sugar-sweetened beverages is associated with weight gain and a higher risk of future obesity in children. New AMA policy passed calls on the AMA to work to remove sugar-sweetened beverages from the SNAP program and encourage state health agencies to include nutrition information in routine materials sent to SNAP recipients. §

# Babu Wins Two-Year Term as AMA RFS Member

By Dan Hauser, Senior Manager of Communications and Media Relations for the Minnesota Medical Association

MMA member Maya Babu, MD, a neurosurgery resident at Mayo Clinic, was elected by the AMA House of Delegates to a two-year term as the Resident and Fellow Section member of the AMA Board of Trustees on June 18.

"She ran a great campaign and wowed most everyone with whom she met," said Dave Renner, MMA's director of state and federal legislation, who attended the AMA meeting in Chicago. "Her passion, ability, and vast experiences will serve the AMA well."

MMA members Blanton Bessinger, M.D., Paul Matson, M.D., and Steve Driver, M.D., served as Babu's campaign committee.

"I am thrilled and honored to serve as the resident representative on the AMA's Board of Trustees, and I will be a

champion for young physicians to have the opportunity to enter all practice types," Babu said. "In this time of rapid health care change, the AMA must have a strong voice and I will strive to ensure that that voice is a loud advocate to protect the patient-physician relationship."

Babu holds a B.S. in neuroscience and a B.A. in psychology from the University of Minnesota. She graduated from both Harvard Medical School and Harvard Business School.

This article originally appeared on MMA's website, [www.mnmed.org](http://www.mnmed.org), on June 20, 2013.



Maya Babu, MD, testifies at the recent AMA Annual Meeting. (Photo credit: Ted Grudzinski, AMA)





# Electronic Prescriptions and Records

In 2011, a study published in the Journal of American Medical Information Association showed up to a 12% error rate in electronic prescriptions by researcher Karen Nanji, MD. This led to discussions

between many medical professionals questioning the efforts to move towards electronic prescribing and whether we were truly making the right move for patient safety. With the federal requirements for utilization of electronic records, we all know electronic records and prescriptions are here to stay. In the last few years, as medical professionals have become more familiar with electronic prescribing systems there seems to be a consensus that things are moving in the right direction.

When pharmacists report to us about errors or discrepancies in electronic prescribing, we always strongly state that it is important they contact you or your nurses to ensure the errors are corrected in the medical records so the same error does not repeat itself. This is an important safety concern to ensure the patient records are accurate for the next person to take care of that patient. If a pharmacist contacts you about a prescription and you change something that would be different from the original prescription that was transmitted, an important step would be to make sure the patient's records are updated to accurately reflect the changes made.

Preventing hospital readmissions is a hot topic in health care systems. This is especially true now that health care systems are being financially burdened by Medicare based on readmission rates. Pharmacists are increasingly being identified with medication reconciliation and their role as being accessible as the option to "bridge the gap" to ensure patients are properly taking medications through adherence systems to prevent readmissions. This involves not only pharmacists in a hospital setting but also those in the retail sector. Access to electronic records is crucial in this process to ensure proper education and guidance can be provided on a patient medication regimen. Multiple studies show that pharmacist intervention in the time after discharging a patient can substantially decrease the readmission rate.

In 2010, the Drug Enforcement Agency (DEA) released rules to identify a process to allow for the electronic prescribing of controlled substances. Unfortunately, the movement towards adoption of electronic prescribing of controlled substances has been slow. Much of the delay involves meeting the DEA's requirements of getting the software systems certified by an approved third party. This certification involves meeting the strict security standards which the DEA deems necessary to prevent diversion. There are a small handful of approved vendors in the United States which are electronically transmitting controlled substance prescriptions. However, to date,

there are no certified electronic prescribing systems in North Dakota that are operational for controlled substances. We look forward to this process to be operational in North Dakota due to the benefits it will afford the practitioners and pharmacists.

**Ensuring compliance with controlled substance prescription requirements...needs to be taken seriously as recent crackdowns on pharmacies in other states have led to multimillion dollar settlements.**

Ensuring compliance with controlled substance prescription requirements is often a source of conflict for our medical professionals but needs to be taken seriously



Mark Hardy, Pharm D

as recent crackdowns on pharmacies in other states have led to multimillion dollar settlements. This means that prescriptions for controlled substances need to continue to be either verbally transmitted to a pharmacy or given a pen-in-hand signature for those handed to the patient to take to a pharmacy.

As many of you are aware, the Prescription Drug Monitoring Program (PDMP) is run through the Board of Pharmacy office. Throughout the United States there are efforts to integrate PDMPs into electronic health records. In North Dakota, we are committed to this to ensure you, as practitioners, have better and easier access to the PDMP for efficient patient care. The Board has applied for a grant to specifically target integration in the ND Health Information Exchange. This will provide another option for obtaining controlled substance dispensing reports on patients in your practice. We will remain committed to providing this excellent patient care resource to our practitioners and pharmacists, whether or not we receive the grant. We encourage you to continue to use this resource in your practice setting.

In conclusion, electronic prescribing and health records are still in their infancy. Modifications are still ongoing to ensure compliance with laws and provide for ease of use. Over the next few years it is important for health professionals to stay involved in communicating shortcomings of the systems for improvements but also to work as a collaborative team to ensure we can provide the highest level of patient care. §

*Mark is the Assistant Executive Director of the ND Board of Pharmacy. He can be reached at [mhardy@btinet.net](mailto:mhardy@btinet.net) or 701-328-9535.*



# The Future of Medicine

**NORTH DAKOTA MEDICAL ASSOCIATION • 2013 ANNUAL MEETING**

**October 3-4, 2013 • Ramada Plaza Suites and Conference Center • Fargo, ND**

## **THURSDAY, OCTOBER 3**

- 12:00 p.m. **Council Meeting**  
(council members only)
- 3:00 p.m. **AMA Update**  
*Sue Bailey, MD,*  
AMA Board of Trustees
- 4:00 p.m. **House of Delegates First Session**  
Reference Committee of the  
Whole to Follow
- 7:00 p.m. **Annual Social and Dinner**

## **FRIDAY, OCTOBER 4**

- 7:00 a.m. **Breakfast**  
**UND SMHS - Serving North Dakota**  
**Today and Tomorrow**  
*Joshua Wynne, MD, MBA, MPH*
- 8:00 a.m. **House of Delegates Final Session**

- 9:00 a.m. **Understand Overall Health Care Expenses in the National Economy**  
*Timothy Bartholow, MD,*  
Chief Medical Officer,  
Wisconsin Medical Society
- 10:00 a.m. **CMS Update**  
*Mark Levine, MD,*  
Chief Medical Officer,  
CMS Region VIII
- 11:00 a.m. **Break**
- 11:15 a.m. **Payor Panel on Health Care Reform**  
*Eunah Fisher, MD,* Chief Medical  
Officer, Blue Cross Blue Shield  
*Lisa Carlson,* Director,  
Planning & Regulation, Sanford  
*Julie Schwab,* Director North Dakota  
Medicaid Services
- 12:15 p.m. **Lunch**  
**Keynote speaker**  
*Jack Dalrymple,* Governor (invited)

## House of Delegates

**Fadel E. Nammour, MD**

**Speaker of the House**

Thursday, October 3, 2013, 4:00 p.m.

Friday, October 4, 2013, 8:00 a.m.



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

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 the NDMA office at 701.223.9475.

## NDMA Officer Elections

NDMA members nominated for 2013-14 officer positions are listed below. Candidates may be nominated from the floor during the October 3, 2013, House of Delegates session.



### **PRESIDENT**

**Steven P. Strinden, MD, Fargo, ND**

*Nominated by 1st District Medical Society*



### **VICE PRESIDENT**

**Debra A. Geier, MD, Jamestown, ND**

*Nominated by 7th District Medical Society*



### **SECRETARY-TREASURER**

**Fadel E. Nammour, MD, Fargo, ND**

*Nominated by 1st District Medical Society*



### **SPEAKER OF THE HOUSE**

**Misty K. Anderson, DO, Valley City, ND**

*Nominated by 5th District Medical Society*

## Program Description

### **AMA Update**

**Susan R. Bailey, MD**

**AMA Board of Trustees**



Sue Bailey, MD, was re-elected to the American Medical Association (AMA) Board of Trustees in June 2012. A tenacious advocate for physicians and the patients who depend on them, Dr. Bailey has held numerous positions for the AMA and is a recent past president of the Texas Medical Association. Outside of her AMA duties, Dr. Bailey is an allergist in private practice at Fort Worth Allergy and Asthma Associates.

Dr. Bailey will discuss the imperative for physician leadership. She will provide a federal update from the AMA and discuss current topics in Washington, DC, as they relate to U.S. health care, and more specifically, as they affect the practice of medicine in North Dakota. Bailey will highlight AMA's new strategic vision and focus.

### **UND SMHS Serving North Dakota Today and Tomorrow**

**Dean Joshua Wynne**



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.



# The Future of Medicine

NORTH DAKOTA MEDICAL ASSOCIATION • 2013 ANNUAL MEETING

Wynne will provide an overview of the changes happening at the school, including the new building project, the expanding class sizes, and the resources needed to accomplish these important evolutions, including the continued support of NDMA and its member physicians.

## Understand Overall Health Care Expenses in the National Economy

**Timothy L. Bartholow, MD**  
**Chief Medical Officer**  
**Wisconsin Medical Society**



Tim Bartholow, MD, is the Wisconsin Medical Society's Chief Medical Officer. In this role, he focuses on physician and community engagement to promote change in the delivery and payment of health care. He works with the Society's Government Relations team to align strategies for improving health care policy with the Society's objectives of achieving better access, quality, and efficiency in health care delivery. A family medicine physician, Dr. Bartholow provides clinical guidance to the Society's work in data analysis, performance improvement, and accountable-care efforts.

In Dr. Bartholow's presentation, he will show how your clinical decisions drive costs and connect that discussion to an overall understanding of health care expenses on the national level. He will explore the financial impact of coordination of care as a substantial solution to health care spending. This presentation will give you greater awareness of costs and their impact on access to care.

## CMS Update

**Mark A. Levine, MD, FACP**  
**Chief Medical Officer**  
**CMS Region VIII**



Mark Levine, MD, FACP, is the Chief Medical Officer in the Denver office of the Centers for Medicare and Medicaid Services. He is very active in developing and maintaining agency initiatives in clinical quality, payment reform and value-based purchasing. He leads agency efforts to link health system reform to professional values and aspirations.

Dr. Levine's presentation will inform you about the Centers for Medicare and Medicaid Innovation (CMS) with an overview of what the Centers are doing and why, including a review of the medical homes concept. This presentation will help you determine how to utilize the resources of CMS to the fullest extent.

## Payor Panel on Health Care Reform

**Eunah K. Fisher, MD**  
**Chief Medical Officer, BCBSND;**  
**Lisa Carlson, Director of Planning and Regulations, Sanford;**  
**Julie F. Schwab, Director of North Dakota Medicaid Services**



This panel of experts will build off of Dr. Mark Levine's presentation and Dr. Bartholow will moderate. This will be a great opportunity to ask questions of each of the panel members, especially now that the open enrollment period has started nationwide.



## Annual Social and Dinner

The 2013 annual meeting social and dinner will feature activities to benefit medical students and recognition of exceptional service, including the NDMA Physician Community and Professional Services Award and the Friend of Medicine Award.

## AMA Foundation Scholars Fund

The North Dakota Medical Association Alliance invites you to our social at which you can enjoy the company of friends and participate in activities to benefit medical students.

As the largest volunteer arm of the AMA, our Alliances throughout the country raise money each year for medical schools to distribute to deserving students of their choice. The AMA Foundation tracks these donations for medical schools independently in separate accounts. Each dean or dean's designate chooses scholarship recipients based on the funds available.

The NDMA Alliance encourages you to contribute to the Scholars Fund, even if you are unable to attend this event. You may contribute using the registration form included in this brochure, or contribute during the evening social and dinner.

## Continuing Medical Education

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Minnesota Medical Association through the joint sponsorship of Trinity Health and the North Dakota Medical Association. Trinity Health is accredited by the Minnesota Medical Association to sponsor continuing medical education for physicians.

Trinity Health designates this live activity for a maximum of 4 AMA PRA Category 1 Credit(s)<sup>™</sup>. Physicians should only claim credit commensurate with the extent of their participation in the activity.

## Lodging

A block of rooms is reserved at the Ramada Plaza Suites in Fargo. The group rate (\$94-\$114), is available through **September 10, 2013**. Contact the Ramada at 701-277-9000. The Ramada Plaza Suites and Conference Center is located at 1635 42<sup>nd</sup> Street South, Fargo. [www.ramadafargo.com](http://www.ramadafargo.com)

## Cancellation Policy

No refunds will be made after **September 27, 2013**.



## Specialty Society Meeting

North Dakota Chapter of the American College of Physicians  
Friday, October 4, 2013  
UND Medical Education Center  
1919 Elm Street North, Fargo, ND 58102

[http://www.acponline.org/about\\_acp/chapters/nd/news\\_meet.htm](http://www.acponline.org/about_acp/chapters/nd/news_meet.htm)

For more information contact Pam Heisler at 701.780.6129

# North Dakota Medical Association Annual Meeting Registration Form

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Organization \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Guest(s) First/Last Name \_\_\_\_\_

- \_\_\_\_\_ I will attend the Friday breakfast
- \_\_\_\_\_ I will attend the Friday educational program
- \_\_\_\_\_ I will attend the Friday luncheon
- \_\_\_\_\_ I will ONLY attend the House of Delegates meetings

NDMA Members: There is no charge to attend the 2013 Annual Meeting, with the exception of the Thursday evening dinner. Please indicate the number of dinner tickets you wish to purchase below.

\_\_\_\_\_ Number of tickets @ \$50 per person \$ \_\_\_\_\_  
Entrée Choice (indicate quantity):  
\_\_\_ Roasted beef tenderloin medallions with red current jus  
\_\_\_ Pepper crusted halibut with a chile mint sauce

NDMA non-member CME registration fee: \$100 per person \$ \_\_\_\_\_

I wish to contribute to the AMA Foundation Scholars Fund - UND SMHS.  
\_\_\_\_\_ \$50 \_\_\_\_\_ \$100 \_\_\_\_\_ \$200 \_\_\_\_\_ Other \$ \_\_\_\_\_ \$ \_\_\_\_\_

Total amount enclosed \$ \_\_\_\_\_

Please mail this form along with payment before September 27, 2013 to:

NDMA  
PO Box 1198  
Bismarck, ND 58502-1198

Fax credit card orders to 701.223.9476  
 MasterCard  Visa



Name on credit card (please print) \_\_\_\_\_

Card Number \_\_\_\_\_

Exp. Date \_\_\_/\_\_\_/\_\_\_ Phone \_\_\_\_\_

Signature \_\_\_\_\_

ZIP Code (as it appears on your statement) \_\_\_\_\_



# Health Information Technology: The Long View

Since 2010, North Dakota Health Care Review has been working with North Dakota physicians and hospitals on the adoption, implementation, and meaningful use of electronic health records under a partnership with REACH, the HIT Regional Extension Center for Minnesota and North Dakota. As one of 60 HIT Regional Extension Centers throughout the country, REACH is responsible for offering technical assistance to primary care clinicians and rural hospitals to help them become meaningful users of EHR systems. REACH is currently working with about 500 of the estimated 780 primary care providers in the state of North Dakota to help them adopt electronic health records. Of these, 173 have achieved meaningful use Stage 1. Currently, REACH is working with 33 critical access hospitals in North Dakota to help them adopt a certified EHR technology and 15 of them have attested to meaningful use Stage 1.

Through our partnership with REACH we have had the privilege of working closely with Paul Kleeberg, MD, REACH Clinical Director. As a board certified family physician and IT professional who has practiced in both urban and rural settings, Dr. Kleeberg understands the benefits and challenges of adopting electronic health records.



By Paul Kleeberg, MD  
with introduction by Barbara Groutt,  
CEO of North Dakota Health Care Review, Inc.

Since around the turn of the century (the 21st Century that is), there has been a growing collection of literature on the value of information technology and its role in improving the quality and safety of health care delivery. However, until recently, the adoption of this technology was slow. Most all other industries had adopted the use of technology, but not health care. More recently, the upwardly

spiraling costs of healthcare combined with a downward spiral of the economy triggered the passage of the Recovery Act in 2009. This act, passed in order to help boost the U.S. economy, included the Health Information Technology for Economic and Clinical Health (HITECH) Act. This act requires providers and hospitals nationwide to adopt and meaningfully use EHR technology by 2015, and provided a mixture of incentives and penalties to drive adoption forward.<sup>1</sup> Recent data have shown that health information technology has grown significantly across the nation since the enactment of the HITECH act. Between 2008 and 2012, EHR adoption has more than doubled in office practices and more than quadrupled in hospitals.<sup>2</sup>

**While it is clear that EHRs are here to stay, the debate and dialogue concerning the benefits and challenges continue.**

According to National Ambulatory Medical Care Survey (NAMCS) EHR Supplement, EHR adoption has grown among North Dakota physicians from 58% in 2011 to 63% in 2012.<sup>3</sup> This rate of adoption exceeds the national average of about 40%. Another survey conducted in 2011 showed that only 11 hospitals in North Dakota had basic EHRs.<sup>4</sup> By 2012, however, 55% of the 44 hospitals in the state, including 51% of the state's 36 critical access hospitals, had basic EHRs.<sup>5</sup> The national average for that same time period was 56%.

While it is clear that EHRs are here to stay, the debate and dialogue concerning the benefits and challenges continue. A systematic review of the literature on EHRs that was published

in 2006 looked at the impact of health information technology on quality, efficiency, and costs of medical care. Of the 257 studies that met the inclusion criteria, 25% were from four academic institutions with internally developed systems that had been in use for a number of years. As it turns out, those were the only institutions in the study that showed benefits in quality and efficiency.<sup>6</sup> This study demonstrated two things. First, it takes time for the use of an electronic health record at a facility to show benefits. Secondly, local development and enhancement were necessary to create a system that met the needs of the facility. The same holds true today.

I recently attended a meeting where two large health systems talked about the benefits they gained from using electronic health records.<sup>7,8</sup> Both systems had extensive IT staff to help in the design and implementation of the electronic health record. They used a mature EHR product and customized it for their needs. They had the experience and collaboration of other colleagues in the community that were using the same software to augment their implementation with manpower and expertise. The system that had been using an EHR for a number of years was able to show significant benefits.<sup>7</sup> This system had gone paperless in its clinics in 2004 and in its main hospital in 2006.

There are a number of advantages for larger systems based in metropolitan communities when it comes to adopting EHRs. They have greater access to resources and skilled temporary staff. They are able to afford more expensive and elaborate electronic health records. These EHRs have been refined over the years and have been redesigned to meet the needs of integrated systems that have inpatient and ambulatory facilities. Often the larger systems have access to information technology staff that can customize the system to meet their unique needs. Finally, since many of these facilities had electronic health records in place prior to the incentive program and were already doing many of the things meaningful use required, they were able to use incentive dollars to further customize and enhance their technology and work flows to meet their quality objectives.

Rural facilities find themselves in a significantly different situation. Rural and critical access hospitals do not have the same resources at their disposal. Many of them are located in small communities and have limited IT staff. Electronic health records designed for these smaller facilities are typically not as mature. Many EHRs evolved out of billing and materials management systems which added a pharmacy system, then later a nursing documentation system, and finally a provider order entry system designed more for pharmacists who order by vial or tablet than it was for physicians who order by dose. Order sets, which make electronic order entry easier and are

commonly seen in large facilities, are often missing in the smaller hospitals because of the physician and staff time it takes to develop them. To add to the challenge, some of these EHRs lacked a robust physician documentation component making it impossible for the hospital to be independent of the paper chart. Having to manage patient care through the use of both electronic and paper records is inefficient and increases the chance for error.

Finally, in order to meet the needs of the hospitals that were now asking for an ambulatory solution, EHR vendors bought or built an ambulatory component. Hospitals wanted to purchase from one vendor and believed it would provide a seamless interface between hospital and outpatient setting. For these vendors, their development time was short and their staff small. As a result, the first generations of these products were difficult to use and integrate. Most of them did not have a seamless or consistent user interface between the clinic and

hospital system and they were often difficult to use. Additionally, the local facilities' abilities to customize the EHR was very limited so it could not be configured to meet local needs. These issues made it even more difficult for physicians to see the benefits of having an Electronic Health Record.

To add to the challenge of their ambulatory providers adopting the EHR, many of these providers were excluded from the incentive program when it began. Most providers in critical access hospitals and affiliated rural health clinics do not use Medicare part B billing - a requirement to be seen as an

eligible professional. This May, CMS announced that eligible professionals who use method 2 critical access hospital billing will become eligible for the incentive dollars if they achieve meaningful use<sup>9</sup> - but that may be too little too late. Because of the perceived lack of incentive and penalty, there had been little drive to get them to adopt EHRs. To further complicate things, the ambulatory components of these critical access hospitals have been slow to be certified for meaningful use. Together, these have created several additional obstacles for these ambulatory providers.

In my travels to Minnesota and North Dakota critical access hospitals, I've seen physicians struggle to use the EHR. It was easy to see why these providers were unhappy. The products were a generation behind those being used in the large facilities. Some hospitals, through strong leadership and a bold vision, have been very successful at gaining physician and staff buy-in and were using the EHR effectively. There were others who were able to achieve meaningful use by leveraging their nursing, pharmacy, and IT staff while physician participation was minimal. Though this latter method may have enabled these

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hospitals to reach Stage I of meaningful use, it will become more challenging to maintain this approach as the stages of meaningful use become more demanding. It will also be more difficult for them to achieve the benefits that an EHR can provide. Unlike many of the larger facilities that had EHRs already in place, these facilities, frequently short on capital, used their incentives to assist with the purchase and installation of the EHR as opposed to enhancing it.

Vendors who build products for these small hospitals also have faced challenges. They are using all their resources to keep up with the certification requirements for meaningful use and have had little time or resources left to refine the products and increase their usability. Finally, due to the speed of change, they have been challenged in meeting the upgrade and installation demands that their clients require in order to keep pace with meaningful use. Consequently, many small hospitals have found themselves on long waiting lists.

A recent publication in Health Affairs bears this disparity outwardly.<sup>10</sup> They report: “rural hospitals have made substantial progress, with one in eight of them acquiring at least a basic [EHR] system in 2012

alone.... However, the gap between urban and rural hospitals remains.” They went on to say that there should be “a focus on hospitals that are still trailing behind, especially small and rural institutions.” This will become even more important as we progress through the meaningful use stages and the requirements become more demanding.

**In my travels to Minnesota and North Dakota critical access hospitals, I've seen physicians struggle to use the EHR. It was easy to see why these providers were unhappy. The products were a generation behind those being used in the large facilities.**

Despite these challenges, providers in small practices appear to be adopting electronic health records and using them effectively in both urban and rural settings.<sup>11</sup> The highest relative increase in adoption was among physicians with historically low adoption levels such as older physicians, those working in solo practices and community health centers. The authors found that in 2012, physicians in rural areas had higher rates of adoption than those in urban areas and physicians in counties with high rates of poverty had rates of adoption comparable to those in areas with less poverty. The authors state that small practices continue to lag behind but the gap has closed significantly. They attributed that to the work of the regional extension centers whose targets were small primary care practices and those serving the underserved.

There are many good products for the ambulatory environment. The American Academy of Family Physicians (AAFP) rates EHR products regularly and has found that many rate very highly in physician satisfaction.<sup>12</sup> Some of these products are designed so that they require minimal maintenance on the part of the practitioner and can be used with minimal need for IT support. The ambulatory

<sup>1</sup> <https://www.federalregister.gov/articles/2010/07/28/2010-17207/medicare-and-medicaid-programs-electronic-health-record-incentive-program> Published July 10, 2010, accessed July 24, 2013

<sup>2</sup> [http://www.finance.senate.gov/imo/media/doc/HIT%20Testimony%20\(F%20Mostashari\)%207%2013%202013.pdf](http://www.finance.senate.gov/imo/media/doc/HIT%20Testimony%20(F%20Mostashari)%207%2013%202013.pdf) Dr. Farzad Mostashari's report to the United States Senate Committee on Finance Wednesday, July 17, 2013, 10:15 AM

<sup>3</sup> <http://www.cdc.gov/nchs/data/databriefs/db111.htm>

<sup>4</sup> <http://dashboard.healthit.gov/HITAdoption/?view=0> Published February 2012, accessed July 30, 2013

<sup>5</sup> <http://dashboard.healthit.gov/HITAdoption/?view=0> Published February 2013, accessed August 1, 2013

<sup>6</sup> Wu, Shinyi, et al. “Systematic review: impact of health information technology on quality, efficiency, and costs of medical care.” *Annals of internal medicine* 144.10 (2006): 742-752.

<sup>7</sup> “Using e-Health in Transforming Health” Alan Abramson, PhD, HealthPartners, Inc. <http://www.health.state.mn.us/e-health/summit/summit2013/>

s2013plenary2abramson.pdf Published June 13, 2013, accessed July 25, 2013

<sup>8</sup> “Minnesota E-Health Summit” John C Smylie, Essentia Health <http://www.health.state.mn.us/e-health/summit/summit2013/s2013plenary2smylie.pdf> Published June 13, 2013, accessed July 25, 2013

<sup>9</sup> [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CAH\\_Method\\_IL\\_Participation\\_FactSheet.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/CAH_Method_IL_Participation_FactSheet.pdf) Published May 2013, accessed July 28, 2013

<sup>10</sup> DesRoches, Catherine M., et al. “Adoption Of Electronic Health Records Grows Rapidly, But Fewer Than Half Of US Hospitals Had At Least A Basic System In 2012.” *Health Affairs* (2013).

<sup>11</sup> Hsiao, Chun-Ju, et al. “Office-Based Physicians Are Responding To Incentives And Assistance By Adopting And Using Electronic Health Records.” *Health Affairs* (2013).

<sup>12</sup> Porter, Sheri. “From the North American Primary Care Research Group: Family Physicians Provide Feedback on Electronic Health Records in FPM'S User Satisfaction Survey.” *Annals of Family Medicine* 11.1 (2013): 84.



practices that use these products are not of concern. What are concerning are practices, affiliated with a rural or critical access hospital, where the integrated software may be less usable and there may not be the financial incentive to assist ambulatory providers with adoption. Two of the 3 EHRs that have integrated products did not have a high enough response rate from physicians in the AAFP study to be evaluated. The one that did was rated at the bottom of 31 products in overall satisfaction.

The vendors who serve the rural and small provider community are working hard to enhance the usability and integration of their products and have shown significant progress. But these facilities need more than that. In future policymaking, we must pay extra attention to rural facilities that are going to need assistance to continue to adopt, enhance, and optimize their use of electronic health records. Most started later than their urban colleagues and do not have the same support mechanisms available to them. The HIT regional extension centers, funded by the HITECH Act, have been identified as being a significant assistance to these practices in hospitals,<sup>2,11</sup> however, their contracts are set to expire in February of 2014. If we do not figure out a mechanism to provide affordable support and technical assistance to these facilities, the digital divide will only grow wider and the quality, efficiency, and safety of healthcare in our rural communities will fall behind.<sup>3</sup>



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**How long has it been since you have had a “personal life goals checkup”?**

**443 I Memorial Highway, Mandan, ND 58554**  
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 DOFU: 1-2012 TR# 447565

# New App Allows for HIPAA-Compliant Texting



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

But a new smartphone app is changing all that.

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

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

- send HIPAA-compliant text messages and photos
- assign an urgency setting to outgoing text messages
- search a local pharmacy directory

- search a local medical society directory (including email addresses and photos)
- Invite your staff to communicate with you through the app

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

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

## HIPAA-compliant text messaging

Message content can include patient information, such as diagnosis, test results, or medical history. Physicians can also add a high-resolution image of an EKG, an x-ray, lab report, or anything that can be photographed with a smart phone to the message.

Messages can then be sent using the app’s messaging priority system.

Physicians can assign each message a 5-minute or 30-minute priority. “If the recipient does not answer the message within 5 minutes or if the message does not get to the doctor, you will then get a message back stating that it did not make it,” says Dr. Gueramy. “You can see and hear that the message you receive is different from any other text.”

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

NDMA is proud to offer this application to all NDMA members. We are working with the DocBookMD staff to implement this service in the coming months. We will publish up-to-date information on our website and in the weekly newsletters. This app provides protection for all parties involved: the patient, physician, and hospital or clinic. As soon as this service is available, we will let you know! §

## UNDER CONSTRUCTION

Excuse our mess while we work on our new website. Watch [ndmed.org](http://ndmed.org) for updates!

Our new site will offer interactive capabilities and a fresh new design, but if there’s something that you think we’re missing, let us know!

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



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**NDMA**  
NORTH DAKOTA MEDICAL ASSOCIATION



# NDMA signs letter of support for HR 1827

*The NDMA along with 41 medical organizations joined the Connecticut State Medical Society in signing a letter to members of Congress supporting the Pediatric Subspecialty and Mental Health Workforce Rehabilitation Act (HR 1827). The legislation extends the current loan repayment program for pediatric subspecialists and providers of child and adolescent mental and behavioral health services working in Health Professional Shortage Areas, Medically Underserved Areas or other areas with Medically Underserved Populations. The legislation is consistent with NDMA policy ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents.*

Dear Member of Congress,

As physicians, we are all aware of the serious health outcomes that can result from reduced access to care. This is especially true for children and adolescents, particularly in the areas of mental and behavioral health care.

We ask for your support of the **Pediatric Subspecialty and Mental Health Workforce Reauthorization Act (H.R. 1827)**. Co-sponsored by U.S. Reps. Joe Courtney (CT-5), Jim Langevin (RI-2), John Lewis (GA-5), Jim McDermott (WA-7), Mike Quigley (IL-5), Jan Schakowsky (IL-9), and Paul Tonko (NY-20), the bill extends the current loan repayment program for pediatric subspecialists and providers of child and adolescent mental and behavioral health working in Health Professional Shortage Areas, Medically Underserved Areas, or with Medically Underserved Populations.

Originally a component of the ACA (Sec. 5203, "Investment in Tomorrow's Pediatric Health Care Workforce"), the program provides critical support for pediatricians and pediatric mental health professionals – yet it is scheduled to end this year. H.R. 1827 will extend the program and continue to support these vital pediatric care services.

## **Our children cannot wait:**

- 55% of US counties have no practicing mental health professionals. (NAMI Policy Brief)
- In 2012, 80% of children with a potential mental health need did not receive any psychosocial therapy; over 70% did not have any mental health office visits. (GAO report)
- A 2009 study found that pediatricians were more likely than adult primary care physicians to be unable to refer their patients to outpatient mental health services due to a shortage of pediatric mental health providers. (*Health Affairs*)
- Fewer new doctors are choosing careers in pediatric subspecialties and pediatric mental health care, while the existing workforce continues to age. (Pediatrics, 2013)
- The average student loan debt for pediatrics increased 34% from 2006-2010, and pediatrician salaries are also considerably lower than many other specialties. (Pediatrics, 2013)

American families should be able to access the medical care their children need, rather than waiting for a health crisis and being forced into the emergency department – or the juvenile justice system.

As state medical societies and medical specialty societies, we ask that you stand with America's families and their children who are suffering and need our care. Your support of H.R. 1827 sends a clear signal that children are our nation's most important resource, and those who provide their care need and deserve our help.

Sincerely,

# Sincerely,

John A. Foley, MD  
President, Connecticut State Medical Society

Carolyn Drazinic, MD, PhD  
President, Connecticut Psychiatric Society

Sandra Carbonari, MD  
President, CT Chapter  
American Academy of Pediatrics

Brian Keys, MD  
President, CT Council of Child & Adolescent Psychiatry

Martin J. Drell, MD  
President, American Academy of Child & Adolescent Psychiatry

Jeffrey J. Cain, MD  
President, American Academy of Family Physicians

Thomas K. McInerney, MD  
President, American Academy of Pediatrics

Ardis Dee Hoven, MD  
President, American Medical Association

Jeffrey A. Lieberman, MD  
President, American Psychiatric Association

Tom Rothe, M.D.  
President, Arizona Medical Association

Omar Atiq, MD  
President, Arkansas Medical Society

Jan M. Kief, MD  
President, Colorado Medical Society

W. Scott Bohlke, MD  
President, Medical Association of Georgia

Eldon A. Trame, MD  
President, Illinois State Medical Society

Gordon M. Hughes, MD  
President, Indiana State Medical Society

Victoria Sharp, MD  
President, Iowa Medical Society

William Harrison, MD  
President, Kentucky Medical Association

Dieter Kreckel, MD  
President, Maine Medical Association

Brian H. Avin, MD  
President of MedChi, The Maryland State Medical Society

Ronald W. Dunlap, MD  
President, Massachusetts Medical Society

Kenneth Elmassian, DO  
President, Michigan State Medical Society

Daniel Maddox, MD  
President, Minnesota Medical Association

Steven L. Demetropoulos, MD  
President, Mississippi State Medical Association

Shaun J. Gillis, MD  
President, Montana Medical Association

P. Travis Harker, MD, MPH  
President, New Hampshire Medical Society

Sambaiah Kankanla, MD  
President, New Mexico Medical Society

Sam L. Unterricht, MD  
President, Medical Society of the State of New York

Michael P. Moulton, MD  
President, North Carolina Medical Society

A. Michael Booth, MD  
President, North Dakota Medical Association

Neal J. Nesbitt, MD  
President, Ohio State Medical Association

D. Robert McCaffree, MD  
President, Oklahoma State Medical Association

Frances E. Biagioli, MD  
President, Oregon Medical Association

Alyn Adrain, MD  
President, Rhode Island Medical Society

Daniel J. Heinemann, MD  
President, South Dakota State Medical Association

Stephen L. Brotherton, MD  
President, Texas Medical Association

Brian Hales, MD  
President, Utah Medical Association

Norman Ward, MD  
President, Vermont Medical Society

Russell C. Libby, MD  
President, Medical Society of Virginia

Nicholas Rajacich, MD  
President, Washington State Medical Association

Hoyt J. Burdick, MD  
President, West Virginia State Medical Association

Timothy G. McAvoy, MD  
President, Wisconsin Medical Society

Michael Tracy, MD  
President, Wyoming Medical Society

# Financial Rx: Two Things to Do After Med School and Two Ways to Build on it

Ask anybody what the highest paid professions are, and pretty soon after “athlete” and “reality star” you’ll find “doctor.” And while it is true that physicians and surgeons carry worthy salaries, something that won’t occur to the average person is the amount of school debt physicians carry. According to the Association of American Medical Colleges, the average debt burden coming out of medical school in 2011 was \$156,456—compared to around \$20,000 for graduates of other fields.

“Nearly every graduate struggles with student loan debt these days,” says Mike Stein, of Securian Financial Advisors of North Dakota. “But the Association of American Medical Colleges found that medical students have faced a nearly seven percent rise in tuition, just in the past few years.”

Fortunately, there are a number of ways med school grads can help ensure their financial futures while still preparing for a long, rewarding career.



Mike Stein

**According to the Association of American Medical Colleges, the average debt burden coming out of medical school in 2011 was \$156,456—compared to around \$20,000 for graduates of other fields.**

One most common-sense piece of advice, according to Stein: Don’t incur more debt.

“The student debt burden out of medical school is tough enough,” Stein advised. “Adding in revolving credit card debt is a risky, and unnecessary, game.”

Once a physician is out of the first few years of post-medical school, and financially stable, Stein said, it’s all about building on that early success. Once you’ve begun private practice, two more major steps will help with that long-term goal of financial security.

1. **Think About Insurance Early:** Disability insurance and health insurance are extremely important to every working American, but even a small disability can cripple a physician’s ability to work. Make sure you secure private disability insurance as soon as possible, ideally while still in medical school, and increase its coverage to the maximum amount as soon as possible. During residency or fellowship, consider taking out personal liability insurance, which will help protect you in the event of a lawsuit. And, finally, it may be a good idea to take out a convertible term life insurance policy, which will provide you with the proper amount of coverage for your entire lifecycle. Your needs and family situation will inevitably change overtime, and convertible term life insurance will be locked in place to protect you – as long as payments are made on time, you cannot be dropped from the policy for a change in health or family status.

2. **Start Saving and Setting Goals:** Every year you put off saving for retirement and unexpected expenses is another year wasted. No matter what you’re making now, consider saving a significant portion of it—between 10% and 25%. Don’t be fooled by your first few paychecks into thinking you have money to burn. Set goals and plan carefully: establish an emergency fund, set a solid debt reduction plan in place, and determine your overall long-term financial goals. And retirement? Don’t wait until you graduate to begin contributing—contribute to the max, if possible, to your employer’s retirement plan.

1. **Think About Retirement:** Continue to save each month, which will be an important life-long safety-net, but once you’re into private practice, it will be important to begin looking at retirement plans. Maximize your Roth IRA, employer’s 401K, and pension. If you own a private practice, compare SEP (Simplified Employee Pension) and SIMPLE (Simplified Savings Incentive Match Plan for Employees) plans carefully, as each has its own unique benefits, depending on your situation.

2. **Increase Your Insurance:** Once dependents and a family come along, you may want to convert your life insurance to permanent coverage. Up your liability insurance as well to form a stable and comprehensive malpractice insurance. It may not be pleasant to think about, but even the most skilled physicians should be prepared for a malpractice lawsuit, and this insurance will help protect your practice in a worst-case scenario. Equally important is to maximize your private disability insurance during this time, in case a more personal worst-case scenario should occur, and you can no longer work.



Every year you put off saving for retirement and unexpected expenses is another year wasted. No matter what you're making now, consider saving a significant portion of it—between 10% and 25%.

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With a comprehensive strategy for each stage in the medical student, and then physician, life-cycle, your life and career can be better protected.

“The more you plan, and adjust your plans to fit your future needs, the more financially stable and successful you will be,” Stein said.

If you have any questions specific to your situation, consider consulting a financial advisor. Every professional is unique, and your career is worth the investment. From medical school to retirement, it's all about strategy and protection.

Life insurance products contain fees, such as mortality and expense charges, and may contain restrictions, such as surrender periods. One can lose money in this product.

Mike Stein is a registered representative and provides securities and investment advisory services through Securian Financial Services, Inc., a securities dealer, and member FINRA/SIPC. Securian Financial Advisors of North Dakota (“SFAND”) is independently owned and operated. Mike Stein and Securian Financial Services do not provide specific tax or legal advice. Consult a qualified tax or legal advisor regarding your situation. SFAND’s home office is located at 4431 Memorial Highway in Mandan. The company also has advisors working in Bismarck, Mayville, Steele, and Valley City. For more information or to locate an advisor, please call 701-663-8401 or visit [www.securiannnd.com](http://www.securiannnd.com).

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TR # 683630 DOFU 6-2013

# The Slow Crawl Toward Improved EHR Usability and Interoperability

**W**ell-developed electronic health records hold the promise of helping health care professionals improve patient care and deliver it more efficiently, and the American Medical Association recognizes that enhancing EHR usability and interoperability will further ensure our nation's goal of a high-performing health care system. Physicians are generally prolific users of technology: new patient monitoring devices, diagnostic imaging, equipment and advanced surgical tools, to name a few. In each case, physicians have adopted these tools quickly and became proficient users – and they have done so without the need for a national incentive program. Why is it, then, that so many physicians are still trying to incorporate EHRs into their practices?

While the Medicare/Medicaid EHR incentive program can be credited with sparking a rapid adoption of health IT, it has also created negative consequences. Swift implementation of certified EHRs, needed to obtain incentives under the meaningful use program, has compelled physicians to purchase tools not yet optimized to the individual user's needs. These tools often impede, rather than enable, efficient clinical care. EHRs can also pose challenges as a physician attempts to meet documentation, coding and billing requirements. AMA has been an outspoken advocate for health IT improvements and continues to work with the federal government and other stakeholders to advance usability and interoperability.

## EHR Usability

According to the Healthcare Information and Management Systems Society, “usability is one of the major factors

– possibly the most important factor – hindering widespread adoption of [EHRs].” Surprisingly, the Office of the National Coordinator for Health IT does not provide physicians any information about the usability of EHRs that it certifies. Usability standards should be included in ONC's certification criteria to ensure that physicians are able to invest in the EHR system that fits the needs of their practice.

Many physicians report they are unhappy with the EHR products available to them, likely due to the fact that EHRs are still in an immature stage of development. They find them clunky, confusing and complex, and they are struggling to successfully incorporate

**While the Medicare/Medicaid EHR incentive program can be credited with sparking a rapid adoption of health IT, it has also created negative consequences. Swift implementation of certified EHRs, needed to obtain incentives under the meaningful use program, has compelled physicians to purchase tools not yet optimized to the individual user's needs.**

EHRs into their workflow. According to a recent survey of physicians by American EHR Partners, approximately one-third of all surveyed physicians said that they were very dissatisfied with their EHR and that it is becoming more difficult to return to pre-EHR productivity levels.

Given this decrease in productivity, it is no surprise that since the start of the meaningful use program, we've seen continued escalation in physician dissatisfaction with their EHRs.



Steven J. Stack, MD

According to the same American EHR Partners survey, the percentage of physicians who would not recommend their EHRs to a colleague increased from 24% to 39% between 2010 and 2012.

AMA also is concerned about the viability of the thousands of certified EHR products. We've heard from many physicians who have invested in

EHRs that have gone out of business. These physicians, who were doing their best to adopt EHRs, are now faced with the financial hardship of purchasing an entirely new system. The uncertain future of an EHR extends beyond the product's business model to the security of the product's certification status. In fact, ONC recently revoked the certification of two EHR systems so providers cannot use those EHRs to satisfy meaningful use requirements. Physicians who have already invested in these now-uncertified systems will need

to spend even more money on a new, certified EHR to replace their non-certified EHR or face a penalty.

## EHR Interoperability

In addition to the usability challenges surrounding the use of EHRs, physicians also face a nascent and often uncertain health information exchange environment, including interoperability challenges associated with the ability of different EHR systems to share patient information with one another.


**Physicians are doing their best to successfully adopt health IT, but more must be done to advance usability and interoperability. AMA is actively engaged with the administration to communicate the concerns of physicians and is pushing for criteria that would make certified EHR systems more user friendly for physicians and meaningful use Stage 2 requirements more flexible.**

Unless physicians and other health care providers are able to securely, accurately and effectively exchange health data about their patients, health IT's promise for enabling high-quality and efficient care cannot be realized. A survey by the Bipartisan Policy Center revealed that more than 70% of clinicians surveyed identified lack of interoperability, lack of an information exchange infrastructure and cost of setting up and maintaining interfaces and exchanges as major barriers to health IT use.

Interoperability of EHRs will become more of an issue as physicians attempt to successfully participate in advanced stages of meaningful use. The meaningful use program has been structured such that each stage calls for physicians to meet an increasing number of requirements, including ones that call for more robust data exchange. This requires expensive, customized EHR interfaces so physicians can connect with other systems. Simply increasing the data exchange requirements physicians must meet in meaningful use will not solve the underlying challenges that persist around the operability of EHRs and HIE, things that are generally outside

the average practicing physician's control. Adding to this are the ongoing concerns that the requirements for meeting meaningful use are too one-size fits all and don't accommodate all the different physician practice patterns and workflows. Layering these requirements on top of requirements that mandate physicians use certified systems that are clunky to use makes for a challenging adoption environment.

Physicians are doing their best to successfully adopt health IT, but more must be done to advance usability and interoperability. AMA is actively engaged with the administration to communicate the concerns of physicians and is pushing for criteria that would make certified EHR systems more user friendly for physicians and meaningful use Stage 2 requirements more flexible. While we believe that CMS and ONC's decision to postpone rulemaking for Stage 3 is helpful, more

must be done to address concerns with Stage 2, which begins Jan. 1, 2014. AMA will continue to highlight these issues and press CMS and ONC to address them before that date. 

*Source: California Healthline  
iHealthBeat, May 30, 2013  
www.californiahealthline.org  
www.ihealthbeat.org*

**Many physicians report they are unhappy with the EHR products available to them, likely due to the fact that EHRs are still in an immature stage of development. They find them clunky, confusing and complex, and they are struggling to successfully incorporate EHRs into their workflow.**



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# ACA's Essential Health Benefits to have Significant Impact on Payers, Physicians and Patients



Kenneth Fischer, MD

The passage of the Affordable Care Act (ACA) represents the largest transformation in the U.S. health care system since the introduction of Medicare and Medicaid in 1965.

One aspect of the ACA that will have a significant impact on the North Dakota health care system is the new Essential Health Benefits (EHB) package. Non-grandfathered insurance plans in the individual and small group markets, both within and outside marketplaces or “exchanges,” must include EHB in 10 categories, including prenatal and postnatal care, preventive care and screenings, and mental and behavioral health services.

The Institute of Medicine (IOM) committee of the National Academy of Sciences released a report in October 2011 at the direction of the U.S. Department of Health and Human Services (HHS), developing a framework for defining minimum “essential” benefits. Each state has identified its own EHB benchmark plans complete with required benefits coverage.

EHB will forever change relationships between providers, payers, and patients. Changes will occur through EHB design, integrated care, shared savings, and risks tied to evidence-based and outcomes-driven care. The ACA expects insurers, providers, and state governments to engage in dialogue around an iterative process in service of increasingly evidence-based, specific, and value-based EHB benefits over time.

But the changes also represent an opportunity to improve care and access. By 2022, an estimated 27 million uninsured Americans are expected to receive health care coverage (15 million through exchanges, 12 million through an expansion of Medicaid). While change always presents challenges,

it also presents opportunities for improvement. There is plenty of room for improvement in the U.S. health care system.

The United States has the highest per capita health care spending of any industrialized nation (50 percent higher than the second-highest spending country and twice the European average), according to an Institute of Medicine report. More than one sixth of the U.S. economy is made up of health care spending and the Centers for Medicare & Medicaid Services (CMS) projects that health care spending will reach \$4.8 trillion and comprise nearly 20 percent of the country's Gross Domestic Product (GDP) by 2021. This is not sustainable.

Despite its outsized health care spending, the U.S. health care system trails other industrialized nations in quality and efficiency metrics. A much-discussed 2000 World Health Report ranked the U.S. health care system 37th in the world.

In 2006, the U.S. had the highest per capita health care spending, but ranked 36th in life expectancy and 39th in infant mortality rate, according to the World Health Organization. Our system is expensive with outcomes that fall below expectations, fragmented care, a lack of transparency in cost, quality and outcomes, and insufficient patient engagement. But some of that is beginning to change.

Doctors and insurers are beginning to look at health care costs, quality, collaboration, and transparency in different ways. Blue Cross Blue Shield of North Dakota (BCBSND) is beginning to reimburse providers more on achieving quality benchmarks and less on quantity of services provided (or the traditional fee-for-service model). Many insurers and providers nationwide are forming Accountable Care Organizations (ACOs) to help better coordinate care. Programs such as BCBSND's MediQHome, a medical home model that helps doctors and providers better coordinate care for patients with chronic conditions such as diabetes and hypertension, are gaining momentum.

The IOM recommends taking a balanced approach to determining EHB that takes into consideration affordability of coverage and evidence-based, medically-effective services. Benchmark EHB plans offered on the "exchange" are models for other plans to follow, but flexibility is allowed. The initial design of existing small employer group plans can be converted to incorporate necessary parts of the benchmark plan. Exchange plans must fit in one of four metallic levels of actuarial coverage.

**Doctors and insurers are beginning to look at health care costs, quality, collaboration and transparency in different ways. BCBSND is beginning to reimburse providers more on achieving quality benchmarks and less on quantity of services provided.**

In time, EHB requirements will likely be updated by the federal government as new evidence-based data and more specific focus areas are identified. This too will add costs. Per the ACA, costs must be considered in initial and any future EHB updates to ensure affordability and protect the intent of the ACA.

Health insurance works by pooling risk across a group or population. Medically-necessary care is paid for through shared resources, prompting the question: "Which services should be paid for using the group's shared resources?" The U.S. health care system continues to search for ways to improve performance, quality, and health outcomes. It will continue to evolve,

adding ACOs, medical home programs like MediQHome, and total cost of care reimbursement arrangements to place more emphasis on patients and better coordinating care.

ACA will profoundly impact patients, providers, and insurers. Its clear intent is to drive the health care system to use limited resources in a way that provides the highest-quality care for the largest group of patients possible. At the same time, doctors, other providers, and insurers are being held accountable to objective requirements in an attempt to measure the value of services provided to patients. EHB is really about an ACA vision in a new environment with new rules.

In "Turning Doctors into Leaders" Thomas Lee in the Harvard Business Review (April 2010) perhaps best captures our work ahead:

*"Traditional health care leaders try to buy time, fend off change, and maximize revenue under the existing payment system while they can. The new leaders focus on outcomes and use performance measurement as a motivating tool to organize their colleagues and drive improvements.*

*Health care delivery is fragmented and chaotic, principally because of an explosion of knowledge and technological advances. Taming this chaos requires a new breed of leaders at every level.*

*Health care's new leaders must organize doctors into teams; measure their performance not by how much they do but by how their patients fare; deftly apply financial and behavioral incentives; improve processes; and dismantle dysfunctional cultures.*

*By organizing care delivery around patients' needs—an idea more radical than it sounds—the leaders of cutting-edge health care organizations are raising the quality, efficiency, and value of the services they provide." §*

*Dr. Fischer is Medical Director of Behavioral Health at Blue Cross Blue Shield of North Dakota.*

# AMA Alliance

The AMA Alliance 2013-14 year is well underway! Our June Leadership Development Conference and Annual meeting got our year off to an exciting start with 150 physician spouses from across the country congregating for an energetic and enthusiastic experience.

Last year, we hired Next Wave Group out of Severna Park, Maryland, as our association management company. This decision has put us on the right path. We have the expertise we need to be a relevant and growing 21st Century organization. We have a 3-year strategic plan to guide us. This past year was spent getting our internal affairs in order. We are blessed to have committed board and committee members to help us go to the next stage of our plan.

Our main focus is and always will be our members and their needs as part of the family of medicine. It is the role of the national organization to speak with one voice to support our county and state affiliates with leadership training, legislative information, programming, and projects that can be implemented where our families live and where our members want to make a difference. As

**We ARE the  
voice of the  
family of  
medicine.**

your partners in the physician family network, the AMA Alliance values our relationship with medical associations. It is by working together that we can achieve legislative results that benefit the patients you care for while preserving the interest of the profession. We need each other!

Because our work in health promotions is so important, we have taken the steps to form a new foundation, the Alliance Health Education Initiative (AHEI). In June 2014, that board will be awarding grants to support health projects at the grassroots level. Our Health Promotions committee has totally revamped our Project Bank to make it up to date, and user friendly, with the latest award winning health projects, including “how to” develop a project. These projects are stellar examples of the good work being done by physician spouses in their local communities.

One of the best things about serving as national president is the connection we make with physicians and physician spouses across the country. For a number of years, I’ve enjoyed friendship and collegiality with Dinah Goldenberg, ND Alliance Chair. Dynamic by nature, Dinah continues her connection to the alliance. I’m sure she’d be the first to tell you that the leadership training opportunities through the AMA Alliance fostered her growth that has led her to run for elected office and serve as President of the School Board in Fargo.

It can be the same for anyone who takes advantage of what our connection offers. There is no other group that understands what being “married to medicine” means. Our alliance of the future will build on that premise as we develop more programming and



Jo Terry, AMA Alliance President

outreach to our current and potential members.

It was my attendance at such a regional meeting in 1985 in Atlanta that gave me “the national bug”. I was pregnant at the time with our third child and Bill’s parents came to our house to stay with our young daughters so that I could attend the meeting.

Our Board’s new physician-in-training spouse representative, Liz Walker from Utah, reminds me very much of myself when I attended that meeting in Atlanta. Liz is pregnant with her third child and her in-laws kept her two little girls so she could attend our meeting. She is just as eager to learn as I was.

There are some things that don’t change—good things like Liz’s enthusiasm—and that gives me hope for our future. There must be many more like her—men and women—and we want them to know about the alliance and to choose to belong.

We ARE the voice of the family of medicine.

I welcome your input as we seek to serve. You may contact me at: [President@amaalliance.org](mailto:President@amaalliance.org).

Sincerely,  
Jo Terry, AMA Alliance  
President 2013-14





**W**ith the rampant technological innovations of the past decades, the transition from paper-based charts to electronic health records (EHRs) was inevitable. What you might not have expected, however, is the need for new business skills in order to get the most out of this new technology.

Choosing the right system, for example, requires a business analyst mindset to find the most compatible solution for your organization's systems. Implementing a new EHR calls for project management skills as you integrate its use throughout a cross-functional staff.

Managing sensitive data requires a working knowledge of IT security and governance. And to leverage that data for a measurable impact on patient health, you'll delve into the world of data analytics.

Those are a lot of roles for any physician to fill. Keep in mind, though, that it's the sociotechnical aspects – the way you and your staff interact with an EHR – that will largely determine the success you will achieve with it. That's why it is so important to view your system as not simply a replacement for paper-based records, but as a presence that's felt throughout your organization and work processes.

If you're not yet tapping into the full power of your EHR, you should look into making adjustments in its use and how you utilize the data. Improvements can be conducted on a micro-level – adjustments you can make yourself – and on a macro-level, which may require some assistance. Here are a few things you can do right away.

### What you can do yourself:

**1. Identify and empower your technology champions** – If you have no internal IT department, use the natural talent and skills of your own staffers. Is there someone who gravitates toward technology and enjoys learning and



Devon Thomas Treadwell  
Communications Consultant to MMIC

problem solving? He or she can teach others a few tricks and timesavers, helping to reduce frustration and increase productivity.

- 2. Invest in training** – Everyone who uses your EHR system should receive adequate training, whether in a group setting, through one-on-one guidance, or by way of electronic tutorials.
- 3. Share best practices** – If your organization has multiple departments, schedule a quarterly huddle between key users from different areas to share optimization ideas and cautionary tales.
- 4. Explore your EHR's advanced features** – You may not be using some of the functionality that most directly improves patient care, such as physician alerts, reminder systems, and performance tracking. One study<sup>1</sup> showed that physicians who used the higher-level functions of EHRs demonstrated improvements in chronic disease management and preventive service delivery.
- 5. Insist on consistency – Avoid workarounds.** Some EHR design constraints can be frustrating, but bypassing the system can endanger patients. Enter data directly into the EHR instead of writing it on a piece of scrap paper to enter later. Get rid of your Post-It® Notes. Avoid cutting and pasting progress notes, vital signs, or other information. Respect alerts and warnings.
- 6. Suggest improvements** – Help improve your EHR technology by documenting any issues and reporting them to your IT department, vendor, or the manufacturer.


Getting the most from your EHR – really harnessing its power – requires continuous evaluation of your practice's goals and improvement to your work flows. From a broad perspective, consider these questions and how you would answer them for your practice:

- Does your EHR meet your needs and goals?
- Do work flow processes need to be re-evaluated?
- Is additional training required?
- Are you capturing the required data elements needed for internal clinical priorities, as well as for reportable quality measures?
- Do staff roles and responsibilities need adjustments?
- Is the technology in the appropriate locations?
- Is the technology reliable?
- Is the technology “fast enough”?
- Is additional hardware needed?

Addressing the answers to these questions and making other sweeping improvements may be best accomplished with the help of experts. You’ll likely find that a small investment in expertise will make a significant improvement in your system’s effectiveness.

#### What you can do with some assistance:

- 1. Get an optimization assessment** – Make a small, short-term investment in an optimization assessment, which can identify conflicts between your work flow and EHR, problems with application design, usability issues, and other obstacles. For specific issues, you can often get the help you need from the software manufacturer or an online user group. For ongoing support, consider a service contract with a local IT provider.
- 2. Leverage the data** – The information collected by your EHR should be used to further improve your clinic’s processes and the quality of care. If you lack the time or know-how to analyze the data and identify opportunities, consider contracting with an experienced consultant. A modest investment can result in an EHR that not only helps your practice operate more smoothly and accurately, but can also improve patient outcomes.
- 3. Launch a continuous quality improvement initiative** – An EHR is not a “set it and forget it” system. To get the most from it, implement a continuous process improvement cycle. The federal government provides a primer to help you get started.<sup>2</sup>
- 4. Take advantage of free resources** – A Health IT Regional Extension Center (REC)<sup>3</sup> is an organization funded by the HITECH Act specifically to assist health care providers with their EHR technology. One such REC is StratisHealth in Minnesota, which, in addition to other services and resources, provides a best practices framework to help clinics select, plan, implement and optimize their EHR.<sup>4</sup> There are many other sources of reliable free information – such as HIMSS<sup>5</sup> and the Office of the National Coordinator for Health Information Technology<sup>6</sup> – all geared toward helping you implement and improve your system.

Your EHR is far more than an electronic alternative to paper records. When you maximize its potential, you’ll have a clearer understanding of your patients’ health, so you can make better decisions for their care. That’s powerful technology. 

#### References:

1. [www.healthit.gov/providers-professionals/ehr-implementation-steps/step-6-continue-quality-improvement](http://www.healthit.gov/providers-professionals/ehr-implementation-steps/step-6-continue-quality-improvement)
2. [www.healthit.gov/sites/default/files/tools/nlc\\_continuousqualityimprovementprimer.pdf](http://www.healthit.gov/sites/default/files/tools/nlc_continuousqualityimprovementprimer.pdf)
3. [www.healthit.gov/providers-professionals/regional-extension-centers-recs#listing](http://www.healthit.gov/providers-professionals/regional-extension-centers-recs#listing)
4. [www.stratishealth.org/expertise/healthit/clinics/clinictoolkit.html](http://www.stratishealth.org/expertise/healthit/clinics/clinictoolkit.html)
5. [www.himss.org/resource/library/TopicList.aspx?MetaDataID=543&navItemNumber=13263](http://www.himss.org/resource/library/TopicList.aspx?MetaDataID=543&navItemNumber=13263)
6. [www.healthit.gov/providers-professionals/ehr-implementation-steps](http://www.healthit.gov/providers-professionals/ehr-implementation-steps)

## REGIONAL EXTENSION CENTERS IN THE MMIC SERVICE AREA

### ARKANSAS

[www.hitarkansas.com](http://www.hitarkansas.com)

### ARIZONA

[www.azhec.org](http://www.azhec.org)

### COLORADO

[www.corhio.org](http://www.corhio.org)

### GEORGIA

[www.ga-hitec.org](http://www.ga-hitec.org)

### HAWAII

[www.hawaiihie.org](http://www.hawaiihie.org)

### IOWA

[www.telligenhitec.org](http://www.telligenhitec.org)

### ILLINOIS

[www.ilhitrec.org/ilhitrec](http://www.ilhitrec.org/ilhitrec)  
[www.chitrec.org](http://www.chitrec.org)

### INDIANA

[www.healthbridge.org](http://www.healthbridge.org)

### KANSAS

[www.kfmc.org/index.php/health-information-technology](http://www.kfmc.org/index.php/health-information-technology)

### MICHIGAN

[www.mceita.org](http://www.mceita.org)

### MINNESOTA, NORTH DAKOTA

[www.khareach.org](http://www.khareach.org)  
[stratishealth.org](http://stratishealth.org)

### MISSOURI

[www.assistancecenter.missouri.edu](http://www.assistancecenter.missouri.edu)

### NEBRASKA

[www.widerivertec.org](http://www.widerivertec.org)

### OKLAHOMA

[www.ofmq.com/health-it](http://www.ofmq.com/health-it)  
[www.o-hitec.org](http://www.o-hitec.org)

### SOUTH DAKOTA

[healthpoint.dsu.edu](http://healthpoint.dsu.edu)

### TENNESSEE

[www.tnrec.org](http://www.tnrec.org)

### WASHINGTON

[www.wirecqh.org](http://www.wirecqh.org)

### WISCONSIN

[www.whitec.org](http://www.whitec.org)

# Health IT brings power to the people.



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Visit [MMICHealthIT.com](http://MMICHealthIT.com) to learn more.





**2013**

# Events Calendar

## September 28

North Dakota Society of Eye Physicians and Surgeons Annual Meeting, Buffalo City Rotisserie Grill, Jamestown, ND.

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

## October 3-4

NDMA Annual Meeting, Ramada Plaza Suites, Fargo, ND.

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

## October 4

North Dakota Chapter American College of Physicians 2013 Annual Meeting, UND Medical Education Center, Fargo, ND.

For information about this and future meetings, please contact Pam Heisler at 701-780-6129

## October 19

North Dakota Psychiatric Society Annual Meeting, Hilton Garden Inn, Fargo, ND.

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

## October 31 - November 2

North Dakota Academy of Family Physicians Annual Meeting, Alerus Center, Grand Forks, ND.

For more information, contact Brandy Jo Frei at 701-772-1730 or email [brandy@ndafp.org](mailto:brandy@ndafp.org)

## May 2-3, 2014

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

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