# Family Medicine Quarterly

**Volume 31, No. 3** **Fall 2005**

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***Roger W. Schauer, M.D., Co-Editor***

Greetings and best wishes to you as you return to fall activities. I suspect all of you have been reading about the horrendous health care challenges faced by the Gulf coast population and health care providers who stepped in to help, either by receiving evacuees or going to the devastated areas. Many have reached out to help, just like many of you reached out to help us in the Red River Valley in 1997. However bad we thought 1997 was, it was not even a warm-up.

Many of you are already aware that Dr. Elizabeth Burns stepped down as chairperson of the Department of Family Medicine effective September 1, 2005. I refer you to her article for details. Dr. Burns will continue to be active in the department and the Medical School. In an accompanying article Dean Wilson names Dr. Milton Smith of the Minot Center for Family Medicine as interim chair effective September 1st through December 31st of 2005. Dr. Robert Beattie from Hettinger has agreed to assume chairmanship of the department effective January 1, 2006. We look forward to working with both Dr. Smith and Dr. Beattie.

Dr. Bittner's President's message addresses the "Future of Family Medicine" Project, and points out that in North Dakota we are doing several things right. Dr. Robert Bowman, long a nationally recognized leader in Family Medicine, appears to agree with her in his report on medical education and health policy. Please note the nine characteristics he used to rate the state of health care education. The enclosed article from North Dakota Health Care Review which reports on the current status of health information technology in ND also speaks to the future.

Congratulations to Christina Brown, a third year medical student at UNDSMHS, for being named as one of ten AMA Foundation Minority Scholars in the country. Christina is currently completing her Family Medicine clerkship and has voiced an interest in pursuing Family Medicine residency training. Associate Dean DeMers again provides us with the characteristics of the 63 incoming students that will comprise the class of 2009.

Please provide feedback to us about the new format for the Family Medicine Quarterly. Our Executive Director, Brandy Jo Frei, has taken the lead on the new design. Also note her article about AAFP and NDAFP events, and a report about the Don Breen Externship this past summer.

In "Dissecting North Dakota Heathcare" Dave Peske brings us up to date on activities of the North Dakota Legislative Assembly during the 2005-06 interim. His article calls our attention to a number of issues that are important to the practice of medicine in this state. "The North Dakota Tobacco Quit Line" article provides evidence for effectiveness of this unique program as well as how your patients can access the program.

Library Resources are available for those of you who teach and precept our Family Medicine clerks. The article by Barb Knight informs you how to access library resources remotely and discusses new information resources available to you. I also refer you to the article "Orienting Family Medicine Residents and Medical Students to Office Practice." While a number of com-

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| Josh Ranum | Second Year |
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| Jennifer Beckwith | Fourth Year |

ments by Dr. Jain might pertain more to residents, the article is also relevant for those teaching medical students. Because of tight schedules and the pressure to be more efficient in the clinic, some of her suggestions may save you time in the clinic when you are teaching our students as they transition to hands-on learning in year 03. Dr. Jordan J. Cohen, President of the American Association of Medical Colleges, suggested the need for more ambulatory care teaching time during medical school when he addressed issues about the future of medical education during his "Dean's Hour" presentation on September 8.

We call your attention to upcoming meetings and continuing education opportunities, namely the annual North Dakota Medical Association meeting in Grand Forks September 22 and 24 and the Big Sky meeting January 16th through the 20th, 2006. Many of you have already participated in the centennial celebration when Dean Wilson visited many of your communities throughout North Dakota. Hopefully many of you will also be able to attend the celebration on campus in conjunction with Homecoming September 29th through October 1st.

We look forward to seeing you or hearing from you.

Roger W. Schauer, MD

The *Family Medicine Quarterly* is published by the North Dakota Academy of Family Physicians and the Department of Family Medicine. Except official reports and announcements, no material in the *Family Medicine Quarterly* is to be construed as representing the policies or views of the North Dakota Academy or Department of Family Medicine. Printed at UND Press. The Editors reserve the right to accept or reject any article or advertisement matter.

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## A Message from The President

***Heidi Bittner, M.D.***

Hello, everyone, and happy September! With the changing leaves this year comes a change in my life--I'm in the twilight of my thirties (actually, the sun is pretty much set) as I turn 40 later this month. This milestone makes me take a look at my life, and ponder what my future holds, and, of course, consider the future of family medicine, too.

It seems recruiting a family doc gets more and more difficult. Over the past decade, the number of US grads choosing a family medicine residency has dropped by 50%. When I look back on my last week of practice, I've seen such a wide variety: diabetics, hypertensives, epileptics, OB's, well-baby checks, crouping kids, sports physicals--the bread and butter of family medicine. But I've also seen patients with hemachromatosis, Klinefelter's, Morquio syndrome, AVM's, CATCH 22 chromosome deletion, autism, broken arms, trauma from a fall off a cat walk, Sjogren's/CREST, cervical cancer--and the list goes on. I do sclerotherapy, remove toenails, perform C-sections, pierce navels and am just starting to do Botox injections. In family medicine, the only limits we have are those we set ourselves. I can't imagine myself in any other type of practice.

When I think of the Future of Family Medicine Project, I think North Dakota is already doing most everything listed! We offer a full basket of services to our patients, coordinate specialty care when needed, encompass more EHR every day, foster research, and, above all else, offer competent, affordable, accessible, and compassionate care. I think we need to stop looking elsewhere to find great family medicine, because the future of family medicine in North Dakota is RIGHT HERE, RIGHT NOW! It's in our own back yard...

I'm looking forward to seeing many of you at Night With A Family Physician and hearing what our AAFP President Larry Fields has to say. I just received my (20 pound) book of resolutions to review before the Congress of Delegates convenes in San Francisco at the end of the month--and am again amazed at the scope of issues we family docs are involved in.

My best to all of you for a wonderful autumn.
Heidi

## A Message from the Executive Director

***Brandy Jo Frei, Co-Editor***

Yes, it was me. I was the one that suggested the new "look" for the quarterly. We are trying lots of new things lately. As with the last issue, the *Family Medicine Quarterly* can be viewed online before the hard copies are even printed. As our Big Sky 2006 brochures get mailed out they state, " The NDAFP is now able to accept credit cards." Credit card acceptance is available for conference registration and foundation donations. Both of these can be done using a secure link on our website. If the information is called or mailed in to me, I will simply go online and input the information.

Along with the office changes, we also have some representative changes. Alisa Boyer has become our first year medical student representative. Alisa will be meeting with second year representative Josh Ranum, faculty advisor Kim Konzak-Jones, and myself to discuss the year to come for the Family Medicine Interest Group. Hopefully the FMIG representatives will assist us in promoting the Don Breen Externship for the summer of 2006. The 2005 summer found 13 externs across the state. All of the evaluations came back with extremely high marks. Those that participated enjoyed themselves, learned a lot, and either maintained or increased their interest in family medicine.

There are lots of activities coming up with the AAFP and the NDAFP. I hope you are all able to attend the AAFP Annual Scientific Assembly every few years and annually attend the NDAFP events. The Evening with a North Dakota Family Physician, on September 15th is a great opportunity to encourage the medical students to choose family medicine. I hope to see you there.

As always, please do not hesitate to contact me with any questions, concerns, or suggestions that you may have.


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# A View From UND

***Elizabeth A. Burns, M.D., M.A.***
***Department of Family Medicine***

I write this as I am in the midst of transitioning from department chair to director of the North Dakota Women's Health CORE (Clinical, Outreach, Research, and Education): A National Center of Excellence in Women's Health Region VIII Demonstration Project and continuing on as medical director of the UND Physician Assistant program. This is a decision that will take me in a direction full of new possibilities. As many of you know, the Department of Family Medicine spearheaded an application for a federal contract for a National Center of Excellence in Women's Health Region VIII Demonstration Project last year. We were awarded this contract, which calls for the director (that would be me) to spend 50% time on the project. The project was slow to take off, but now we are at a point where there are more people to meet and partner with and lots of interest in the Project statewide. We are participating in North Dakotans Partnering for Health, which sponsors the First Lady's Women's Health Conference and have contacted Senator Dorgan's Office about his Women's Health Conference. Our website (http://www.und.nodak.edu/dept/womenshealth) has lots of new information on it thanks to coordinator, Sarah Owens. We are focusing on monthly topics and will be posting ND specific information on domestic violence and health resources. I would encourage you to look at it and send us feedback. I look forward to sharing our plans and programs with you in the years to come.

The Center for Rural Health was just awarded a Geriatrics Education Center grant. Guy Tangedahl is the Principal Investigator and Dr. Rosanne McBride and I will be assisting him on the medical student and resident curriculum portion of this project. This exciting project will also help us expand geriatric services in Bismarck at the Center for Family Medicine there.

I would like to thank all of the family physicians in North Dakota and Minnesota who make our teaching program possible. I've had the opportunity to meet many of you and look forward to meeting more of you in my new role. It's been a pleasure working with you these past 3 years as chair.

**The North Dakota Tobacco Quitline**
Meeting the Challenge of Tobacco Use in North Dakota

Tobacco use is currently the #1 preventable cause of death in North Dakota, with Heart Disease and Cancer leading the way in morbidity and mortality. Tobacco related illnesses have a significant impact on North Dakotans, with nearly $200 million spent annually in direct medical costs. Approximately 130,000 North Dakotans use Tobacco Products presently. The rate of high school age smokers is among the highest in the U.S., and the use of spit tobacco is above average as well.

In response, the North Dakota Department of Health formed a partnership with the University of North Dakota School of Medicine and Health Sciences Department of Community Medicine and the Mayo Health System Nicotine Dependence Center to start a Tobacco Quitline Program for all North Dakota Tobacco users desiring to quit. Mayo was selected as a partner due to their success in the 3 other states where they operated Quitlines, with 6 and 12 month tobacco cessation rates at 30% and 27% respectively. This compares with 3 to 5% success rate of smokers trying to quit on their own, with no support.

The Quitline service went 'live' on September 20, 2004, and to date, the tobacco cessation rates are exceeding expectations, with 3 month and 6 month quit rates at 55% and 40% respectively. The Quitline service is not a "tobacco hotline", but a true counseling service; callers receive up to 5 counseling sessions from trained tobacco cessation counselors. Counselors at the UND center hold professional degrees in other areas such as Respiratory Therapy or Counseling. All counselors receive rigorous training at the Mayo Nicotine Dependence Center in Rochester, Minnesota.

Physician Consultants for the Project are Dr. Donna Anel, MD, MPH and Dr. Eric L. Johnson, MD. Unlike the other states where Mayo operates Quitlines, promotion of the Quitlines are limited only to mass-media advertising. In North Dakota, Dr. Anel and Dr. Johnson are making themselves available for CME presentations regarding Tobacco Cessation and the use of the Quitline as a medical tool in helping patients stop using tobacco products. For more information, please contact them at the Department of Community Medicine at the UND School of Medicine. Supervising Physician for the project is Dr. James Brosseau, Department Chair of Community Medicine.

The toll-free number for the North Dakota Tobacco Quitline is 1-866-388-7848 (1-866-388-QUIT) (TDD 1-866-257-2971)

Any North Dakota resident can use this service free of charge Income qualified patients may qualify for nicotine replacement products free of charge.

For more information, contact The North Dakota Department of Health-Kathleen Mangskau (kmangska @state.nd.us) or the Department of Community Medicine at the University of North Dakota School of Medicine and Health Sciences: Melissa Gardner(ostlund@medicine.nodak.edu) 777-3191.

**HETTINGER PHYSICIAN NAMED CHAIR OF FAMILY MEDICINE AT U.N.D. SCHOOL OF MEDICINE AND HEALTH SCIENCES**

Dr. Robert Beattie, a family physician in Hettinger, has been named chair of the Department of Family Medicine at the University of North Dakota (UND) School of Medicine and Health Sciences, Dean H. David Wilson has announced. His appointment is effective Jan. 1, 2006.

He replaces Dr. Elizabeth Burns who has resigned as chair effective Aug. 31. Dr. C. Milton Smith, a faculty member at the medical school's Minot Center for Family Medicine program, will serve as interim chair beginning Sept. 1 through Dec. 31.

"We want to thank Dr. Burns for directing the Department of Family Medicine and for making several significant improvements. She has worked to attract important national grants to improve the health of North Dakotans," Wilson said. "Dr. Smith will do an admirable job as interim chair during the remainder of this year.

"I believe Dr. Beattie, who is an outstanding North Dakota family doctor, has all the skills and personal qualities to move the department forward toward the goal of being one of the best in the nation. We are fortunate to have him join us as the next chairman."

"I am excited to accept the challenge this appointment represents," Beattie said. "As a physician practicing rural family medicine, I believe I will bring a common sense approach to the issues facing the Department in its efforts to train physicians for North Dakota."

A native of Garrison, ND, Beattie has served as president at United Clinic Physicians since 1999 and is chief of the family medicine and obstetrics-gynecology services and chief of staff at West River Regional Medical Center in Hettinger. He is serving his second year as president of the North Dakota Medical Association; his term ends later this month.

For the UND medical school, he is a clinical associate professor of family medicine, a preceptor for the UND Center for Family Medicine in Bismarck and coordinator for the Rural Opportunities in Rural Medicine (ROME) program in Hettinger.

An alumnus of UND, he earned a Bachelor of Science degree in natural science and conducted research as a graduate student in physiology prior to enrolling in the medical school. In 1989, he earned the Doctor of Medicine degree from the UND medical school and took residency training at UND's family medicine program in Bismarck where he also acted as chief resident.

Certified by the American Board of Family Practice, he holds memberships in the American Academy of Family Physicians, the National Rural Health Association and the North Dakota Medical Association (NDMA). He has held several offices in the NDMA and served on the board of directors of the North Dakota Academy of Family Physicians from 1990 to 1996. He and his wife, Susan, a registered nurse, have seven children. Dr. Burns, who has served as chair since November 2002, will remain on the faculty as a professor of family medicine and director of UND's National Center of Excellence in Women's Health Region VIII Demonstration Project. She will continue to serve as medical director of the Physician Assistant Program, be involved in the Geriatric Education Center grant, conduct scholarly activities, teach, and conduct national committee work.

Dr. Smith served as director of UND's family medicine residency in Minot from 1992 until July 1 of this year. He remains on the faculty of the UND Center for Family Medicine in Minot. A native of Whitehall, MT, he attended Minot State University and earned the Bachelor of Science in Medicine degree at the UND medical school in 1969. He earned the Doctor of Medicine degree at the University of Texas-San Antonio Medical School and took residency training at Sioux Valley Hospital in Sioux Falls, SD, and in surgery at UND-affiliated hospitals in North Dakota.

## Hurricane-Stricken States Establish System for Volunteer Physicians

AAFP News Now

Family physicians wanting to volunteer their medical expertise to the victims of Hurricane Katrina can do so by contacting the Mississippi and Louisiana AFPs. The two constituent chapters are coordinating family physician volunteers with each state's health department.

Despite a need that is desperate and both immediate and long-term, public and law enforcement officials in both states have emphasized they will require volunteer physicians to work within a system that will match physicians to health care and geographic needs, said Beth Embry, executive director of the Mississippi AFP, and Sonora Thigpen, executive director of the Louisiana AFP.

Volunteers may contact the Mississippi AFP by e-mail at mafp@netdoor.com or by fax at (601) 957-7552. To volunteer in Louisiana, your best bet is to complete an online volunteer form.

"Because of the tremendous response, we are asking that volunteers complete the online volunteer form to expedite the process," said Thigpen. "Your contact information will be forwarded to the (Louisiana) Office of Emergency Operations ASAP."

Embry and Thigpen asked that FP volunteers use these contact methods to preserve telephone lines for other emergencies. When submitting volunteer offers, include your

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- name,
- telephone number,
- cell phone number,
- e-mail address,
- street address and
- dates you are available to volunteer.

Embry and Thigpen will provide information from volunteers to their respective state's health officials, who will contact volunteers in approximately two to seven days if their services are needed immediately. Some volunteers, however, may not hear from health officials for several weeks.

"The coast was hit quite hard, and there's not much there," said Mary Gayle Armstrong, M.D., District V health officer and medical director of promotions for the Mississippi Department of Health. "Some hospitals are still there, but they are without power and water. Halfway up the state in Jackson, we're having difficulties with the phones. So we are having difficulty assessing the situation, and we don't want to send manpower to a location where they can't function."

Because Mississippi and Louisiana are in states of emergency, their health departments will acknowledge an out-of-state family physician's medical license, said Embry.

Given the gravity of the situation, volunteer physicians should pack to be as self-sustaining as possible, said Thigpen and Embry. That means they should bring their own sleeping bags, as much water and portable food as possible, and other essentials of daily life.

"It's hot and it's messy and there aren't a lot of supplies," said Embry.

**U.N.D. MEDICAL STUDENT NAMED A.M.A. FOUNDATION MINORITY SCHOLAR; ONE OF ONLY TEN IN THE COUNTRY**

Christina Brown, a third-year medical student at the University of North Dakota (UND) School of Medicine and Health Sciences, has been named an American Medical Association (AMA) Foundation Minority Scholar. She is one of only ten medical students in the country to receive the award, which includes a $10,000 scholarship.

The award is given in recognition of Brown's excellence as a medical student and outstanding promise for a future career in medicine.

Brown, a student delegate to the American Academy of Family Physicians, won the Toiyabe Indian Health Service Award for Outstanding Achievement in 2003. She also won a Minority Graduate Exposition Award for a Cell Biology Poster Presentation in 2001 and the McNair Scholar Institute Award in 2000. She has been active in the Native American Student Association.

Associate Dean for Student Affairs Judy DeMers, of the UND medical school, said, "We are very proud of Christina and her accomplishments to date. She is a personable, energetic, caring, highly determined and talented young woman with a very strong work ethic and a clear vision of her future. Her commitment to providing quality medical and health care to her tribe is very genuine and her motivation seems grounded by truly humanistic concerns. I am convinced she will develop into an exceptional physician."

The Minority Scholar Award recognizes scholastic achievement and promise for the future among students in groups defined as historically under-represented in the medical profession. Less than seven percent of U.S. physicians fall within these groups, which include African American/Black, Native American, Native Hawaiian, Alaska Native and Hispanic/Latino.

"We are pleased to recognize the outstanding achievements of Christina Brown, and to provide her with substantial financial assistance," said AMA Foundation President Linda Ford, M.D. The AMA Foundation is committed to introducing more minorities into the medical profession in order to better reflect the needs of our diverse society. We must do all we can to ensure that the cost of medical education remains within reach of our most talented students.

Brown earned a Bachelor of Science degree in biology from the University of Nevada-Las Vegas in 2001, before enrolling in the UND medical school through its Indians Into Medicine (INMED) program. She is taking her third year of medical education with physician-faculty members in Grand Forks.

The AMA Foundation, the philanthropic arm of the American Medical Association, has made a priority of helping medical students handle the rising cost of their education. On average, future physicians graduate approximately $109,000 in debt, and in many cases the debt load is much higher. Minority students in particular often feel the burden of the high expense of medical school, and they tend to carry a higher debt load after graduation.

Since its founding in 1950, the AMA Foundation has contributed more than $90 million in educational, research and public health grants. The Minority Scholar Awards are given in collaboration with the AMA Minority Affairs Consortium and in association with the Pfizer Medical Humanities Initiative.

**Dr. Karl Christian Wold Endowment funds new and expanded electronic resources**
Submitted by Barb Knight

The Harley E. French Library of the Health Sciences is very proud to announce the addition and expansion of several electronic resources that have been made possible by the generous support of the children of Karl Christian Wold, M.D. They have created the Dr. Karl Christian Wold Endowment having the purpose "to assist in acquiring the resources necessary for the UND School of Medicine and Health Sciences to remain the most respected medical library in the region."

Several key clinical information resources are being supported in whole or in part by the Wold Endowment. These resources are available to the medical school's students and faculty, including the volunteer community clinical faculty, throughout the state.

To access these resources remotely go to the library web site at http://harley.med.und.nodak.edu/, then to databases, and select the resource you would like to use. You will get a screen that requests your electronic resources login. Enter your remote access User Name and Password and proceed. If you have a medicine.nodak.edu e-mail account your User Name is your medicine e-mail address and the password is the same as the password you use to access that e-mail account. If you DO NOT have a medicine e-mail account, go to the library home page at http://harley.med.und.nodak.edu/ and select the link for Remote Access application. If you have any questions please e-mail hflref@medicine.nodak.edu or call for Harley E. French Library reference assistance at 701-777-3994.

New resources are:

DynaMed: an evidence-based medical reference system designed for use at the point of care. It contains clinically organized summaries of nearly 1,800 topics and is updated daily from review of the research literature.

Cochrane Library: a regularly-updated collection of evidence-based medicine resources; includes full-text systematic reviews.

InfoRetriever and InfoPOEMS: filtered, synopsized, evidence-based information; includes decision support tools, diagnostic calculators, summaries of evidence-based practice guidelines, 5-Minute Clinical Consult, and the DailyPOEMS. PDA download available.

MDConsult from Elsevier: a collection of over 60 clinical books, nearly 100 full-text journals including the Clinics of North America, a collection of Year Books, practice guidelines, drug information (including Mosby's Drug Consult), medical news, and 6,500 customizable patient handouts. PDA downloads available through Pocket Consult, which includes Mosby's Drug Consult, 20 medical calculators, tables of contents and abstracts you can select from 400 journals.

FirstConsult from Elsevier: evidence-based primary care information system. PDA download available through Pocket Consult.

Access Medicine: a collection of 22 clinical textbooks from the Lange Educational Library, plus the Lange Self-Assessment Tool for the USMLE Step I and Step II.

PsychiatryOnline: 5 electronic journals, DSM-IV-TR Library, APA Practice Guidelines, Textbook of Clinical Psychiatry. psychiatric news.

Notice that many of these products are evidence-based, and many have components that can be downloaded to a hand-held computer.

There are no restrictions on number of simultaneous users on any of these resources. That means you will be able to access them at any time and never get a message such as "Maximum number of users logged on - access denied."

*Words to help deal with the Burdens of Life:*

***We could learn a lot from Crayons. Some are sharp, some are dull. Some have weird names, and all are different colors, but they all have to live in the same box.*

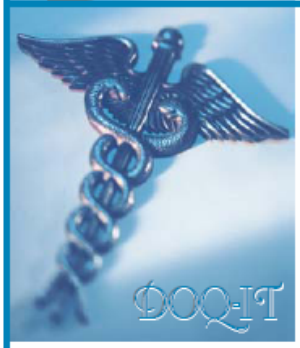
***A truly happy person is one who can enjoy the scenery on a detour.*

***You may be only one person in the work, but you may be the world to one person.*

***Some mistakes are too much fun to only make once.*

*- Authors Unknown*

# Doctor's Office Quality-Information Technology




## *Are you ready to introduce or expand information technology in your practice?*

Doctor's Office Quality-Information Technology (DOQ-IT) is a program designed to assist small to medium primary care physician practices in adopting electronic health record (EHR) systems. The ultimate goal is to improve office efficiency and patient outcomes. This project is being conducted by North Dakota Health Care Review, Inc. (NDHCRI) under contract with the Centers for Medicare & Medicaid Services (CMS) and is starting the fall of 2005.

**PARTICIPANTS IN THE DOQ-IT PROJECT WILL RECEIVE ONE OR MORE OF THE FOLLOWING:**

- Help in evaluating the IT needs and capabilities of your practice
- Guidance in selecting an appropriate EHR system for your practice
- Help in preparing staff and office for an EHR system
- Assistance in analyzing physician office workflow to optimize use of IT
- Ongoing assistance in office work process changes to utilize IT in improving quality/safety, efficiency and cost in managing patients, including those with chronic disease
- Assistance with data submission

**PARTICIPANTS WILL BE ASKED TO:**

- Complete an application to participate
- Complete an initial practice readiness assessment of equipment, staff, patient load, and the status of health information technology (HIT) already in place
- Evaluate EHR systems to identify what products will fit your practice's needs
- Implement or expand an EHR system within the next 12 to 18 months
- Work with NDHCRI and other project participants to share experiences, best practices, project progress, and lessons learned
- Submit quality measure data to the Centers for Medicare & Medicaid Services (CMS) clinical data warehouse

Applications are being taken for the project. To request an application or if you have any questions about the DOQ-IT project, please contact Linda Lumley, llumley@ndqio.sdps.org, or Doug Kjos, dkjos@ndqio.sdps.org, 701-852-4231.

DOQ-IT
Doctor's Office Quality - Information Technology

**NDHCRI Physician Office Health Information Technology Survey Results**

In July, North Dakota Health Care Review, Inc. (NDHCRI) conducted a physician's office survey to help understand the current status of health information technology (HIT) in the state of North Dakota. Following is a brief analysis of the returned surveys. We hope that you will find the survey information useful. We want to thank you for taking time to support our efforts in getting the responses that we did. The survey results will help NDHCRI to move forward in the recruitment efforts for the Doctor's Office Quality - Information Technology (DOQ-IT) Project beginning the fall of 2005. The project is part of a CMS national initiative to encourage providers to implement electronic health records (EHR) in their practice. A total of 308 physician offices were sent the survey with a 51% return rate.

*Who responded…*

- About 1/3 of the responders were single physician practices, another 1/3 included 2-3 physicians, another 1/4 included 4-10 physicians, and the remainder were larger practices.
- About 2/3 of the practices employed midlevel providers (PA/NP) with about 1/3 of the midlevel providers billing independently.
- One-half of the practices were predominantly (i.e., at least 75%) primary care; 19% were entirely non-primary care.
- About 40% of the practices reported more than half of patients being Medicare beneficiaries.

*And their responses …*

- 98% of practices have internet access.
- About 1/3 of practices use e-mail in some capacity to communicate with patients, and just over 10% of practices used the internet as a means of patient-provider communications for appointments, monitoring device data transmission, patient access to medical records, Rx refills, and/or viewing lab/test results.
- Practice management software is used in over 90% of practices, 97% of these practices using it for billing, 84% for registration, and 79% for appointments.
- 50% of practices utilize at least one electronic chronic disease or preventive care registry.
- 20% of practices use an electronic prescribing system.
- Nearly 30% of practices utilize Electronic Health Records, and 80% of those who do not are exploring that possibility. Excluding the 2 large practices using EHR, 7% use EHR.
- Cost and back-loading were the most frequently cited barriers in implementing Electronic Health Records. Education, standardization, and vendor accreditation were rated as most important to make the transition to Electronic Health Records easier.
- 50% of practices have been involved with an effective patient care quality improvement project.
- Over 50% of practices report at least moderate interest in working with North Dakota Health Care Review on EHR implementation over the next 3 years.

If you have any questions or would like more information, please contact Linda Lumley or Doug Kjos at 701-852-4231. Thanks again!

**DISSECTING NORTH DAKOTA HEALTH CARE**

David Peske, ND Medical Association (dpeske@ndmed.com)

**Legislative Committee Interim Studies**

A number of healthcare topics are being studied by the ND Legislative Assembly during the 2005-06 interim. The NDMA staff attended initial meetings of the committees in July, and will provide testimony over the course of the next 12 to 14 months as recommendations are developed. NDAFP members are invited to contact me for information on any of the many topics being studied.

The Budget Committee on Health Care is studying whether a comprehensive study of North Dakota's healthcare needs to the year 2020 should be performed during the 2007-08 interim. Numerous organizations are being called upon to provide information on all aspects of the healthcare delivery system. This committee is also combining several studies of allied health professional licensure, including acupuncturists, and the creation of an umbrella licensing board.

The Budget Committee on Human Services is studying the Medicaid program's medical reimbursement system and management of various programs, the costs and benefits of adopting a comprehensive healthy North Dakota and workplace wellness programs, the effectiveness of state programs in providing services to meet the extraordinary health care needs of children, and the ability of the state's public health units to respond to public health issues. This committee will also receive reports regarding the development of a prescription drug monitoring program, and the implementation of the Part D drug benefit program provided under the Medicare Modernization Act of 2003.

The Industry, Business, and Labor Committee is conducting a comprehensive review of the pharmacy benefits management industry and its impact on drug costs and utilization, and the loss ratio standards for health and accident insurance carriers as regulated by the ND Insurance Commissioner's office. The Committee will also receive a report from the Commissioner regarding the status of the state's liability insurance marketplace.

The Judicial Process Committee will review the legal and medical definitions used in statute to address dementia-related conditions, and the Transportation Committee will study the shifting of medical care costs related to uninsured individuals who are injured in automobile crashes.

**WHY THE FUTURE WILL BE BRIGHTER IN THESE STATES**

Robert C. Bowman, M.D.

I am preparing a report on education, medical education and health policy in American as it relates to family medicine. For the graduation and support of family physicians it takes education investment, broad distribution of education, investment in medical education, admissions of a broader range of students, specific training, and supportive health policy regarding primary care. I have divided states into a top and bottom quartile relative to family medicine and underserved populations in health and education. These rankings do not yet include a rating of direct line-item support for family medicine in terms of specific state funding so they are not yet complete, but I do not expect surprises.

The top and bottom states line up in two camps. There are states that consistently value children, underserved populations, breadth of education expenditures and outcomes, and liability protection and there are states that do not. I would welcome feedback on the criteria and lists. Each state was given 15 points based on state rank in each of the following categories. The low total score for a state across the sum of all categories divided the states into the top and bottom quartiles.

1. Students born in a state and choosing family medicine by percentage of allopathic medical school graduates from the 2004 Masterfile - a direct measure
2. In state medical school positions supported by a state divided by state year 2000 population - without sufficient physicians, a state is basically taking family physicians and other physicians from other states and nations when many can and should finance medical education better.
3. State education per capita compared to national rate of 100% (range 70 - 137%) some states just do not invest enough in education.
4. State share of education when local school districts are left with little option, those with low property values cannot compete, especially rural, inner city, and low income populations, the ones who choose FP at higher levels
5. State distribution of education resources to high and low income school districts
6. State high school graduation rate (states with increased high school graduation graduate more family physicians. Increased high school graduation means more rural and inner city students doing well enough to become young professionals)
7. State liability reform caps (high overhead practices with low volume procedures suffer increase costs without protection)
8. % of poor children in the state not covered by health insurance (also a measure of supportive primary care health policy and funds to primary care)
9. Broader Medical School Admissions of rural born, older, and core urban students - New Jersey has 88% of its medical school admissions from counties of over 1 million or foreign born, the two groups least likely to choose family medicine. Without broader admissions, there is little hope of graduating family physicians. Schools with more rural born and older students graduate far more family physicians.

Those least supportive of family medicine physicians, the patients that family physicians are most likely to care for, and those who represent the future of family medicine as future family physicians: Scores ranged from 31 - 42 in this group. Florida - uniformly low in all categories. Maryland - investments in college, but lacking in education investment and breadth. Connecticut - top high school graduation but no help in other areas. California - one of the lowest investments in education and high school graduation rates in the nation. Pumping 4 billion into stem cell research is leading other states and medical schools further down the wrong path. Texas - reasonable spending on education poor state share of funding, low HS grads. New Jersey - hated to include NJ in the bottom, given the state's strong support of education for all populations, but the scores in other areas were bad. Arizona - leaving poor children behind in health and education. Tennessee - low investment in education and resulting low high school graduation rate. Pennsylvania - narrow admissions, few rural born despite a significant rural population. New Hampshire - should have better education investment and some med ed. Virginia - Liability improvements, improved health care coverage for poor children, increase state share of ed costs would move state from bottom to the top group. Nevada - a state trying in education but growing too fast. Georgia - Lower HS grad despite state funds, rural areas may be worst impacted.

States most supportive, the top group of states listed in order of best states North Dakota, South Dakota, Michigan, Wisconsin, West Virginia, Arkansas, Nebraska, Montana, Vermont, Iowa, Indiana, Kansas, New Mexico, Minnesota. If you would like individual reports on these states, happy to send them.

The difference between the Dakotas and the other states in the FP top rated list was usually only 1 major item or slight improvements in 2 or 3 areas. Every state had one area that could be improved with the exception of Wisconsin that had no major outlier areas to address. Kentucky, Idaho, Utah, Hawaii, Wyoming, South Carolina, Ohio, Missouri, and Alaska were very close on the heels of the top group.

This does not mean that family physicians should not choose unfriendly states for practice locations, but especially for new family physicians going into practice in a less supportive state, they should know that the work is likely to be an uphill battle, especially with health and education policy set against the kind of work we do.

If states and medical schools know that we are observing and telling our patients and voters about state strengths and weaknesses, then we may have a better shot at getting and keeping funding.

Robert C. Bowman, M.D.
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**Characteristics of the Class Entering on August 1, 2005**

The Class of 2009 (entering on August 1, 2005) is composed of 62* individuals. The following provides statistics in relation to class members.

**Sex:** Male = 34 (54.8%) Female = 28 (45.2%)

**Age:** ---at date of matriculation (8-1-05)

Range = 21-44 yrs
Mean = 24.4 yrs
Median = 23 yrs
Mode = 22 yrs

21 yo = 1
22 yo = 20
23 yo = 16
24 yo = 8
25 yo = 6
26 yo = 2
27 yo = 1
28 yo = 2
29 yo = 3
32 yo = 1
41 yo = 1
44 yo = 1

**State of Residence** (8 states)
ND = 45 (1 INMED)
CA = 1 (INMED))
MT = 6 (All WICHE)
IA = 1 (INMED)
MN = 5
OK = 1 (INMED)
AZ = 2 (Both INMED)
TX = 1 (INMED)

**Ethnic Background:** Seven (11.3%) of the students self report an ethnic minority background. Six are American Indian and one is American Indian/African American.

**Majors: Bachelor's Degree -**
Biology/Zoology/Biomedical or Biological Science = 36
Chemistry = 11
Psychology = 7
Religion = 3
Cell Biology = 2
Clinical Laboratory Science = 2
Communication Studies = 2

One major each: (N=13)
Anthropology
Applied Studies
Biochemistry
Chemical Engineering
Classics
Honors
Kinesiology
Latin
Management & Organizational Development
Microbiology
Neuroscience
Philosophy
Women's Studies

**College/University Attended for Bachelor Degree Study (N=28)**

University of North Dakota = 19
Arizona State University = 2
North Dakota State University = 5
Minnesota State University – Moorhead = 2
Concordia College = 4
St. John's University = 2
Montana State University = 3
University of Mary = 2
University of Minnesota = 2

One student each: (N=21):
Augustana College
Spring Arbor College (Spring Arbor, MI)
Colorado State University
St. Cloud State University
Gustavas Adolphus
Texas Tech University
Hamline University
University of California - Riverside
Iowa State University
University of Iowa
Jamestown College
University of Minnesota - Crookston
Minot State University
University of Montana
Montana State University
University of St. Thomas
Northeastern State University (Oklahoma)
Western Washington University
Pacific Lutheran University (Tacoma, WA)
Winona State University
Rocky Mountain College (Billings, MT)

**Major: Master's Degree (N=1)**
Physician Assistant

**College/University Attended for Graduate Study**
Kirksville College of Osteopathic Medicine

*One student who was admitted earlier also will become a member of the Class of 2009, bringing the total to 63. In addition, two of the entering INMED students who are now part of this class will transfer to USDSM at the completion of Year 02.

Judy L. DeMers
Associate Dean for Students & Admissions

The following faculty development article is reprinted by permission from *Family Medicine*, Vol. 37, No. 7—page #461.

*Editor's Note:* In this month's column, Sweety Jain, MD, of the Sacred Heart Hospital Family Practice Residency in Allentown, Pa, discusses important items that should be discussed with residents and students when orienting them to office practice.

## Orienting Family Medicine Residents and Medical Students to Office Practice

Sweety Jain, MD

When new interns begin their family medicine residency, they may have a high level of anxiety as they consider the expectations that faculty and staff have of their office-based skills. Similarly, medical students may feel anxious as they begin an office-based preceptorship, since most of their clinical education occurs in other settings. To allay these anxieties and maintain consistency in a residency practice or a private office, faculty and staff should make efforts to orient new residents and medical students to office practice. This orientation offers the opportunity to present office policies and procedures as well as general expectations of the practice. Faculty and staff should initially cover the following aspects of office practice in an orientation session with learners and then continue to work with each resident and student to ensure that he/she gains the needed office skills in each of these areas. These items may be modified to suit the needs of the individual residency program or physician office.

### Thorough Chart Review

Faculty and office staff should orient residents and students to each section of the patient chart in detail and help them learn how to review new patient charts, established patient charts, and records from other offices or hospitals.

In the case of new patients, learners should review the history form that patients complete about their health, medications, and hospitalizations while waiting to see the physician. Residents and students must pay attention to and thoroughly review this form since there may be important items of history in the form that may be missed if the patient does not mention these to the physician. An important example of this is when a patient is hesitant in talking to the physician about abuse, suicide attempts, or other psycho-social issues but does mention it on the health history form.

For established patients, some residents and students walk into the room without reviewing the chart and then spend a significant amount of time questioning the patient about information that could easily be gathered from a quick chart review. Faculty can teach learners how to conduct a chart review prior to entering the room to make the patient encounter proceed more smoothly. In addition, residents and students can learn to organize the charts of their patients for more efficient practice by adding flow sheets for diabetes, anticoagulation management, or other chronic issues.

When records from other offices are received, learners must pay careful attention to the details in the records. The records may reveal important information such as a patient's noncompliance with tests and office visits or special issues such as narcotic dependence. Based on these findings, the learner may need to modify the diagnostic or treatment plan. Sometimes the old records can inform the learner of the actual diagnosis in the situation when the patient has misinterpreted his/her diagnosis. An interesting example is when patients state that they have had uterine cancer, when they actually have a history of an abnormal pap smear followed by colposcopy and directed cervical biopsy.

### Problem Lists

As part of the orientation to the medical record, faculty should also point out the importance of maintaining an up-to-date problem list. Learners should update the problem list as a new diagnosis is made, ensure that the list records all of the patient's chronic problems and conditions, and add the corresponding *International Classification of Diseases, Ninth Edition* (ICD-9) codes for each condition to save time in coding subsequent visits. Residents and students may find it beneficial to list any significant negative workup with the date to prevent a repeat workup for the same problem that has already been done in the recent past (eg, chest pain, stress test negative 4/05).

### Medication Lists

Similar to the problem list, faculty should orient learners to the medication list and teach them to update medication lists as new medications are added and document the dosage, frequency of usage, and number of refills. A separate sheet may be used for anticoagulants, narcotics, and other special medications. Another helpful item is the name of the pharmacy most frequently used by the patient, along with its telephone number.

### Follow-up of Laboratory Test and Diagnostic Imaging Results

In the orientation session, the faculty and staff should make it clear how the office communicates test results to patients. Many physicians directly communicate test results to patients only if they are abnormal. This is an acceptable practice as long as the patient clearly understands this and is informed of normal test results through an alternative process. Residents should learn to review laboratory test and diagnostic imaging results, initial and date the reports, and then inform patients of normal results by mail or other methods used by the office. (Most practices have preprinted letters for this purpose.)

For abnormal laboratory test or diagnostic imaging results, residents should not only initial and date the report but also inform the patient of the result and discuss how the management plan may be changed. Residents should remember to write a short note on how the abnormal result is handled, either on the report itself or in the chart. An example is "Statin started/to be started" in case of an abnormal lipid profile. For diagnostic imaging results, residents should remember to read the entire report and not just the conclusion, so that they better understand the findings and more urgently follow up that patient if needed.

Medical students are not able to perform all of these steps of handling diagnostic results on their own. However, under the guidance of their faculty preceptor, they can participate by reviewing test results on patients they have seen and making suggestions on how to handle any abnormal results.

**Reminders**
Faculty and staff should inform learners of the reminder system used in the office since some studies may need to be repeated after a certain interval, and often one cannot depend on the patient to remember the need for repeat testing. Residents and students should learn how to activate the physician reminder system used in the office on those occasions, so that the physician will be reminded at the appropriate time to repeat the test.

**Referrals**
As family physicians, referrals are an integral part of practice. Faculty and staff should help residents and students learn not only the process of how referrals are handled in the office but also how to make "SMART" referrals:
• Be **S**ure that the referral is needed.
• **M**ention all tests done so far (attach all relevant reports).
• **A**sk for the consult note from the specialists.
• **R**eaction from the patient should be asked for. It is important to know whether they were satisfied by the care provided by the specialist.
• Form a **T**eam with the specialists by calling them to discuss the interesting cases or inviting them to case presentations.

**Communication**
During the orientation, faculty should emphasize that the key to success of any practice is effective communication. For residents and students, this includes communication with the patients, their families and caregivers, communication with other physician colleagues and staff in the office, and communication with specialists regarding patients referred to them. In the orientation session, faculty can explain how residents or students can practice effective communication skills in these situations from the beginning.

**Time Management**
As in any other profession, time management is an important key to successful practice in medicine. In this part of the orientation, faculty can begin to help learners understand concepts of effective time management and then reinforce those concepts as the rotation progresses. For example, residents can learn to frequently refer to their daily office schedules as they see their patients. Not only does it help them manage their time but also allows them to relieve their stress and spend more time with patients if they know that they have had a no-show or that the next patient has a simple problem that will not take much time. Faculty and staff should also help both residents and students learn an important principle of time management, which is to "learn to listen but also know when to stop."

**Messages**
Faculty and staff should explain how messages are handled in the office and remind residents to check their messages at least once a day since patients expect their physicians to answer their messages the same day. Setting up a consistent system for answering messages is important since patients often judge their doctors on their promptness in returning their messages. In addition, learners should devise strategies to reduce the number of messages. For example, residents and students can help patients understand the need to ask for prescription refills at the time of their visits. They also can proactively inform patients of their test results in the manner described above.

**Documentation**
In the orientation session, faculty should begin teaching how this aspect of office practice is an integral and critical part of learners' training. Residents and students must learn to document not only the patient encounter but also every phone call to the patient, family, pharmacy, consultants, and others. Faculty should repeatedly instill the phrase "Not documented is not done" in residents and students. Good documentation not only enables proper coding for billing purposes but also protects the physician against malpractice claims.

In the final component of the orientation session, faculty can share secrets to help residents and students enjoy office hours. These include:
(1) Expect challenge! While family physicians see many routine cases such as upper respiratory infections and physicals, they also see a number of interesting and complicated cases. Family physicians often have the advantage of knowing their patients well, which gives them an advantage in solving difficult diagnostic and treatment situations.
(2) Follow challenging cases along with the specialists and learn from them as they treat the patient.
(3) View "difficult" patients as a positive opportunity. Instead of getting frustrated by their behaviors, develop different strategies to work with these patients and help them deal with their issues.

Office practices give family medicine residents and medical students the opportunity to learn skills in ambulatory care. By taking the time to orient each resident and student to each of these office issues, faculty and staff can help learners understand how to provide quality care to outpatients and maximize the learning opportunities that are available to them in this setting.

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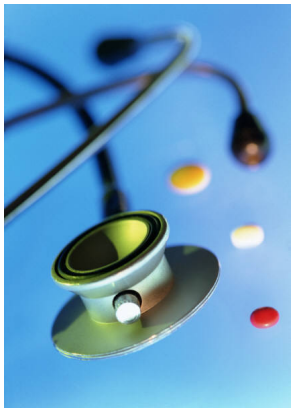
**OPEN POSITION:**
**Program Director** – The University of North Dakota Center for Family Medicine-Minot is seeking a program director to lead a vibrant FM residency program with an emphasis on rural family medicine. The applicant must be a board certified family physician with experience in residency education and administration. Academic rank commensurate with experience. The program is a fully accredited 5-5-5 program located in the upper Great Plains. Please send letter of interest, CV, and references to C. Milton Smith, M.D, Interim Chair, Department of Family Medicine, University of North Dakota School of Medicine and Health Sciences, P.O. Box 9037, Grand Forks, ND 58202-9037, FAX 701-777-3849. UND is an EO/AA employer.



***ASSURE THE BEST FOR YOUR BABY'S PHYSICAL DEVEILOPMENT***

*Pathways Awareness Foundation, a national non-profit organization dedicated to raising community awareness of the benefits of early detection and early therapy for children with physical differences, received an endorsement from the American Academy of Pediatrics for their brochure "Assure the Best for your Baby's Physical Development".*

*The brochure, designed to educate parents and assist medical professionals, includes a growth and development chart highlighting speech, play and physical developmental milestones from 3 to 15 months of age. This unique tool allows parents to become proactive in tracking their child's development and encourages early treatment for delays.*

*To receive your free copies of the brochure to distribute to parents or to get more information call their "parent-answered" toll-free number at 1-800-955-2445, email at friends@pathwaysawareness.org or visit their web-site at www.pathwaysawareness.org*

*Pathways believes early detection is the best prevention.*

## IMPORTANT DATES TO MARK ON YOUR CALENDAR

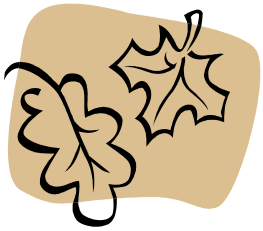
**September 15, 2005**
**Evening With a ND Family Physician**
**Best Western Town House, Grand Forks**

**September 22—23, 2005**
**North Dakota Medical Association Annual Meeting**
**Alerus Center, Grand Forks**

**January 16 – 20, 2006**
**29th Annual Family Medicine Update**
**Big Sky, MT**

**March 23 – 25, 2006**
**51st Annual State Meeting and Scientific Assembly**
**Ramada Plaza Suites, Fargo**

**Fall colors can be seen everywhere.**



# Mark Your Calendar

## *29th ANNUAL*

## *Family Medicine Update*

Huntley Lodge
BIG SKY, MONTANA
January 16-20, 2006

***Sponsored by the North Dakota Academy of Family Physicians***

**Registration Fee - $500.00***
**NDAFP Members—$425.00***
**Out-of-State Medical Residents - $275.00***
**ND Medical Residents—Free***
***By December 1, 2005**
**(Add a $75 late fee for registrations after December 1, 2005)**

**Spouse and Children's Activities**
**Networking Opportunities**
**Family Events**
**For information on Housing Reservations, Daycare Services and Kid's Club, call Huntley Lodge 800-548-4486**

Workshops will be offered.

*Agenda will be available soon—please visit our website at www.ndafp.org

25+ Prescribed AAFP credits will be available.

Send to: NDAFP Big Sky, UND, P.O. Box 9037,
Grand Forks, ND 58202-9037

For further information: (701)777-3276 FAX (701)777-3849 or email: Brandy@ndafp.org or visit our website at www.ndafp.org.

**——————————————————Registration Form——————————————————**

Name: _____ Title: _____

Address: _____

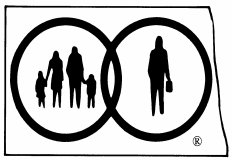
City & State: _____ Zip: _____

Amount Enclosed: $ _____

____I prefer to receive a CD-Rom of conference materials ____I prefer to receive a paper copy of conference materials

If you will bringing guests / family, please indicate:

____Number of Adults ____Number of Children



# Family Medicine Quarterly



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