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**Issues In This Issue**

Roger W. Schauer, MD

This Spring issue of the FMQ is with a sense of urgency regarding some **political issues. SB No.2332**, including the funding initially proposed to address Health Information Technology (HIT), has the potential to significantly impact availability of grant funding for health care facilities in North Dakota. After reading about SB No.2332 (below) please consider contacting your district senators and representatives. More information about HIT will be available at the 2009 Dakota Conference on Rural and Public Health at the Mandan Seven Seas conference on Thursday, April 2, 2009. Final votes on SB #2332 likely will be cast before that date. For more detailed information about the 2009 Dakota Conference or to register for that conference, see <http://ruralhealth.und.edu> . Also see Bruce Levi’s update on the 61st Legislative Assembly for information about other House and Senate bills. .

Dr. Beattie addresses political issues in his “**State of...**” address. Dr. Glunberg’s “**Message**” directly or indirectly ties in with some of my comments below. In this issue you will also find the **2009 Match Day** results to learn which nine of our students matched in Family Medicine. Detailed 2009 match results for the Family Medicine Residencies in North Dakota will be shared in the next FMQ, but for now be aware that both the Minot and Bismarck Family Medicine Residencies filled all five of their allotted positions, the Grand Forks program filled its six allotted positions.

The outcome of **SB No.2332 Health Information Technology** (sponsored by J. Lee)<sup>1</sup> has the potential to have an immediate and lasting impact on all medical practices in North Dakota, but **especially those institutions and practices that serve rural communities**. The exact language of SB No.2332, as reported on the NDMA website, is reprinted below. I am fully in support of the bill as initially submitted, for reasons I will discuss below, but I am concerned about the current form of SB No.2332. The initial appropriation request of \$5,923,572 was reduced to \$500,000 in the Senate, and it is my understanding that the House has further reduced that amount to \$250,000.

Availability and access to **Health Information Technology (HIT)**<sup>2</sup> will be mandatory for survival of any institutions/clinics/systems that receives Medicare/Medicaid reimbursement, as reimbursement will shortly be tied to that technology. Likely all rural systems need that reimbursement for survival. SB No.2332 would establish an HIT office, budgeted for start-up at about \$275,000, but the remainder of the nearly \$6 million would be used to provide grants to local health care facilities, which are challenged financially to come up with the upfront money to even begin implementation. In addition, significant dollars need to be set aside which will be needed in the very near future to be eligible for federal stimulus monies that states will need to compete for. These funds will be used to develop state grant/loan programs for health information exchange. The

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## The State of Family Medicine in North Dakota

Provided for the 61<sup>st</sup> North Dakota Legislative Assembly—Robert Beattie, MD

The last century witnessed many changes in medicine. Prior to 1910 and the publication of the Flexner Report, medicine had little in the way of structure or standards. Early in the 1900s the American Boards emerged in an effort by physicians to define a body of knowledge and to create specific requirements for membership. The first American Board was Ophthalmology (ABO) established in 1917. The American Board of Family Practice (ABFP, later changed to American Board of Family Medicine, ABFM) was recognized in 1969, following reports of The Millis Commission, Folsom and The Willard Committee. The ABFM administered its first exam in 1970.<sup>1</sup>

North Dakota established its first Family Medicine residency in 1975 at Minot, followed by Grand Forks, Bismarck and Fargo. The programs in North Dakota were designed on a community based, school administered model, one of five administrative structures popular at the time:

- Community based, unaffiliated
- Community based, medical school affiliated
- **Community based, medical school administered**
- Medical school based
- Military

The UND School of Medicine and Health Sciences (UNDSMHS) has been very successful, educating a workforce of primary care physicians for North Dakota. Nearly 40% of the 500+ graduates from our Family Medicine residencies practice in the state and 67% practice within the surrounding region.<sup>2</sup>

Family Medicine enjoyed a rapid rise in popularity among graduating medical students, reaching a zenith in 1997.<sup>2</sup> In order to accommodate this demand the infrastructure expanded by developing new residency programs and increasing the number of slots available at existing programs. This period of rapid growth created opportunity for the development of other models to administer these programs, including community based foundations and partnerships with other health providers, such as Community Health Centers.

Concurrent with the height of student interest, the 105<sup>th</sup> Congress passed the Balanced Budget Act of 1997 (BBA). This piece of legislation dramatically altered the Medicare payment environment, demanding, for the first time, a budget neutral expectation. Medicare

Graduate Medical Education (GME) dollars, the principal funding source for residency education, was significantly impacted.<sup>3-4</sup>

Prior to 1997 the average rate of family medicine residency closure was 3 programs per year. However, after BBA, the rate skyrocketed to a total of 27 programs closing between 2000 and 2004.<sup>3</sup> The programs that closed tended to be community based and their loss will disproportionately impact placement of physicians in rural and underserved communities.<sup>5</sup> The Fargo program was one of those 27. Financial reasons are cited as the most common factor leading to closure.

The financial stability of family medicine programs is changing rapidly. In 2001 a study concluded:

*The majority of departments of family medicine remain fiscally healthy, but these departments are dependent on funds from state and medical school sources. A substantial proportion of departments are in debt.*<sup>6</sup>

A recent update to this study, reported at the annual meeting of the Academic Departments of Family Medicine, Feb, 2009 suggests the financial stability of our family medicine departments continue to deteriorate.<sup>7</sup> Much of this change is attributed to continued negative changes in both Medicare physician reimbursement for direct patient care and in GME funding to hospitals. Also contributing, to the present fiscal reality is the continued decline of Title VII grant funding from the Health Resources and Services Administration (HRSA). These dollars were instrumental in providing assistance for infrastructure development during the early years of family medicine and programmatic growth as the departments and supported residencies matured.

The impact of BBA continues to shape the landscape of medicine. A recent article in the Journal of the American Medical Association reports a selective increase by hospitals in subspecialty training while closing family medicine residencies. This study speculates hospitals are re-adjusting their availability of residency training to maximize financial return.<sup>8</sup> The residency model employed for administration offers little in the way of protecting program viability.

As with the financial issues of family medicine training, a great deal of speculation is offered to explain the decline in student popularity since its peak in '97, including control of life style, prestige and significant income disparity compared to other specialties. We are, however, fortunate North Dakota's graduating medical students demonstrate career choices defying the na-

tional trend.<sup>2</sup>

The Executive Budget, with support of the State Board of Higher Education, included requests to increase dollars for program operations and funding of a tuition waver program, called the Rural Med Program. This program, encouraging students from rural communities, pays for the tuition cost of medical school, but commits the recipient to contracted service in rural areas of our state. This approach is used successfully in other states, such as Ohio. The University of Ohio has a 62% in-state retention rate of graduates trained in the state. Their 5 year obligation keeps most graduates practicing in the state after the 5 years are up<sup>9</sup>. The Executive Budget did not, however, include funds needed for a new residency facility in Bismarck and continued support of the Minot facility. It will not matter how many medical students we encourage to pursue family medicine if we do not have competitive facilities for them to use. The Centers for Family Medicine is vital to the continued supply of physicians to the region.

The recent presidential elections focused a great deal of attention on the need for transformation of our health care system. It is unclear how long that debate will take in our nation's capital. We are, if not pioneers, certainly trend setters in the nation regarding the delivery of high quality and efficient family medicine. We are now positioned in our state with the money and the opportunity to influence the continued supply of physicians to the citizens of North Dakota and beyond. The commitment to provide a workforce of trained family physicians is expensive, but if we invest in "growing our own" we will assure the continued availability of that workforce and will return greater value to our patients, the taxpayers of North Dakota. This strategy will be more successful than trying to recruit and compete for physicians trained elsewhere.

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## Executive Excerpt

Brandy Jo K. Frei

Big Sky—Family Medicine Update 2009: What a great conference!!! We had a great turnout, with outstanding speakers, AMAZING weather and ideal snow conditions. For those that were there, you know exactly what I am talking about. For those of you that couldn't make it, register today for the 2010 Family Medicine Update Conference. The dates are January 18-22, 2010. I will see you all there!!!

Spring is a busy time as the committees prepare to meet and we are putting together the annual meeting schedule for June 18-19th in Bismarck. Please look at the agenda for the state meeting and register today.

As always, I am here to answer any questions, listen to any concerns or ideas, and look forward to the year ahead.



NORTH DAKOTA ACADEMY OF  
**FAMILY PHYSICIANS**  
STRONG MEDICINE FOR NORTH DAKOTA

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## Message from the NDAFP President

Steven Glunberg, MD

As the seasons change and we patiently wait for winter to let go of its grip so we can move onto spring, your academy's calendar also moves forward from one event to another. Brandy and the Big Sky Committee have put another successful year at Big Sky behind them. We now are awaiting the results of what we hope will be another successful match for the family medicine residencies in the state. A match that fills our residency spots with high quality physicians will help insure the continued success of our academy and help insure the citizens of our state will continue to enjoy high quality medical care in the future. Our medical student's interest in our specialty is in large part due to the role models they encounter during their family medicine rotations, electives, Don Breen Externship, ROME experience, participation in FMIG activities and countless other formal and informal interactions the students have with practicing family physicians. Our academy and our specialty owe a great debt to each of you who volunteer your time and talents year after year to serve as a role model and demonstrate to medical students the rewards of a career in family medicine. On behalf of the NDAFP I want to say thank you to all of you for your efforts.

The NDAFP's committee structure and board of directors will be meeting by teleconference in March and again in person during the annual meeting in July. Many of you are involved in this process and this is another vital way for individuals to contribute to our academy's future success. I would encourage any member, especially younger members of our academy, to become involved in your organization's operations by volunteering for a committee or running for the board of directors. I am sure you would find it to be a rewarding experience that allows you to work with a great group of people with really a minimal time commitment. Please contact Brandy or any of the NDAFP's current officers if you or anyone you know is interested in becoming more involved with the academy.

Brandy has been working this winter to update the NDAFP website and it will soon be up and running. It is a great looking website and we hope you will find it very functional. You will soon find it at [www.ndafp.org](http://www.ndafp.org) and I would like to encourage all of you to visit it and see how it can work for you. If you notice that something is missing that you think should be included, you can use the website to contact Brandy with your thoughts.

In the summer 2008 edition of the Family Medicine Quarterly I mentioned that we are working with a consulting group to develop our strategic plan and that you would be

contacted by letter and asked to complete a survey. The planning process has been a little slower than expected in getting going, but by the time you read this you should have received the survey I mentioned last summer. I would encourage you to take the time to complete the survey as your input is very important as we look to what we want our academy to be in the future.

Another major upcoming event on our calendar is the 54<sup>th</sup> NDAFP Annual Meeting and Scientific Assembly scheduled for June 17-19, 2009 in Bismarck. Dr. Rich Vetter is chairing the planning committee and is putting together an excellent educational program. I would encourage all of you to try to attend the educational sessions and take advantage of the opportunity to visit with colleagues from across the state. I will look forward to seeing you in Bismarck.

### Issues in this Issue—continued from page 1

federal dollars will provide a match of 10 to 1. Those technology costs are substantial. Many larger systems have already invested extensively in HIT, but to the best of my understanding, their connectivity is generally internal to that system. To gain grant support and ultimately enhanced Medicare and Medicaid reimbursement the electronic medical record (EMR) and health information systems will be required to provide statewide interoperability.<sup>1,2</sup> For more detail please see reference #2 below, submitted by Lynette Dickson.

The HIT issue became even more relevant to me after attending a planning meeting of the **North Dakota Area Health Information Center (AHEC)**.<sup>3</sup> One major AHEC focus is developing a sustaining health care professional workforce pipeline. Availability of and access to HIT will be major recruiting tools for all institutions, and of greater importance for rural communities where physicians and other health-care workers have an even greater need for immediate access, both for information to assist in patient care (which may include access to previous consults or information vital for emergency referral). For more detail about AHEC, see the article by Mary Amundson.<sup>3</sup> For those of you in the East AHEC, look forward to meeting Bill Krivarchka, the recently appointed East AHEC director. More in the next FMQ.

**1. SB No. 2332 (J. Lee) Health Information Technology** -as printed at the NDMA at the website <http://www.ndmed.org/?id=98&ncid=8&nid=12>

This bill would create an HIT office in the Department of Health, advised by a Health Information Technology Advisory Committee. The bill would appropriate \$5,923,572 to the Department for the purpose of defraying the cost of the office and advisory committee and associated grants. The bill would require the advisory committee to make recommendations for im-

plementing a statewide interoperable health information infrastructure that is consistent with emerging national standards, promote the adoption and use of electronic medical records and other health information technologies, and promote interoperability of health information systems. The committee would also develop a grant program to assist in the planning and implementation of HIT projects and establish a 501(c)(3) entity for the purpose of accepting and expending funds from the federal government, private industry or other sources. NDMA supports SB No. 2332 as a vehicle for addressing HIT this session. *The Senate passed the bill, reducing the appropriation to \$500,000.*

## 2. What we know about Economic Stimulus for HIT

– submitted by Lynette Dickson, Center for Rural Health and Chair-ND HIT Steering Committee. (Steering Committee’s website <http://ruralhealth.und.edu/projects/sorh/hit.php>)

1) It is our understanding, at this point, that there will be “some” dollars funneled into existing grants (e.g. HRSA, AHRQ, etc.) which will be made available fairly soon; this will still be grants which ND facilities will need to compete for and now there will be increased competition.

2) Next - there will be dollars available for loan/grant programs to states or a ‘designated entity’ to support health information exchange(HIE) planning and implementation (HIE remains to be defined) planning/implementation – which has a required state match (10:1 starting in 2011).

We are fairly confident that there won’t be a lot of money dumped directly into states for EHR implementation. We know that the ND facilities, especially rural are not at even the minimum level of EHR adoption necessary to be considered a ‘meaningful user’. Because the majority of ND rural facilities are critically challenged financially, the upfront dollars to invest in the technology in order to even think of being able to get the incentives in the end remains an obstacle. So- the state grants would be another opportunity to provide support to them.

**Note:** It is my understanding that during the ND OMB meeting held about the stimulus (March 5th) it was stated that that the HIT funds will be coming "directly to providers" – which is in part correct, via Medicare/Medicaid enhanced incentives starting 2011. **However**, it is critical that the legislators, etc. know that support is still very much needed to get the facilities, especially rural, to a level of EHR adoption in order to be a ‘meaningful user’ (Definition still to be defined by the Sec. DHHS) but the following has been discussed on national calls – must use a certified EHR, be able to exchange quality data (what data TBD), be part of a health information exchange (what is HIE TBD), and e-prescribing (clinics only); which will be a requirement to be eligible to access the Medicare/Medicaid incentive dollars.

**Also important to note**, if physicians and hospitals are not ‘meaningful users’ of EHR the incentive program will be phased in to penalties for not adopting.

### What the HIT Steering Committee is currently doing.

We are staying in close contact with Congressional offices with regard to the stimulus package

1) Developing a DRAFT plan for the state HIE system so we have a guesstimate on cost to implement.

2) Completed analysis of how this will impact critical access hospitals if the do adopt an EHR and if they don't and enter the

penalty phase.

SB2332

Started \$5.9 million establish an HIT office and a grant program  
Cut to \$500,000 Senate Appropriation's

Cut 3-16-09 - \$250, 000 House Human Services

## 3. North Dakota AHEC (website at <http://ruralhealth.und.edu/projects/ahec/>)

- Submitted by Mary Amundson from the Center for Rural Health

The University of North Dakota School (UND) of Medicine and Health Sciences (UNDSMHS) in partnership with the UND College of Nursing (UNDCON) received a federal grant from the Health Resources and Services Administration to plan, develop, and implement an Area Health Education Center (AHEC) program in North Dakota (ND). This proposed program, the North Dakota AHEC, includes a state-wide plan to incrementally develop three AHECs in the East, Northwest and Southwest regions. The initial grant will focus on the East AHEC, consisting of 21 counties, from the Canadian to the South Dakota borders.

The three main goals of the ND AHEC are to establish an infrastructure to increase distribution, diversity, supply, and quality of health care personnel responsive to both state and local community health care delivery needs, enhance the quality of health professions education by utilizing academic resources across ND, and to increase the number and diversity of providers serving in rural underserved areas. These goals will be accomplished by linking the resources of the university health science centers with local planning and education by providing student-based opportunities in the community, not the university.

The North Dakota AHEC is designed to provide continuing education and interprofessional clinical opportunities for students in medicine and nursing at the college and graduate level. As the program matures, other academic institutions and health care disciplines will be included in the program. Health career awareness programs will be available for students’ kindergarten through graduate programs to inform students and parents about careers in the health care field utilizing the Health care Workforce Pipeline chart to guide the activities.

Initial funding for the North Dakota AHEC includes the US Department of Health and Human Services Bureau of Health Professions along with match contributions by the University of North Dakota, the University of North Dakota Vice President for Research, the University of North Dakota School of Medicine and Health Sciences, the University of North Dakota College of Nursing and the Dakota Medical Foundation.

## 61<sup>st</sup> ND Legislative Assembly

### A Work in Progress

Bruce Levi

As the 2009 ND Legislative Assembly churns forward and Congress considers health care reform, it is evident these are changing times for medicine and health care in North Dakota. With new leadership on board or pending at BCBSND, the UND School of Medicine and Health Sciences, Workforce Safety & Insurance, several health care systems, the ND Healthcare (hospital) Association, ND Health Care Review, Inc. and the UND Center for Rural Health, we are likely in transition to new and different ways of addressing the health care needs of our state.

Recently returning from Congressional visits and an AMA Advocacy Conference, Kim Krohn, NDMA president Robert Thompson and I discussed the need for North Dakota to ensure that new Medicare payment policies are beneficial to our state and do not further penalize us or further exacerbate the huge disparity in Medicare physician payments we receive compared to other states. Things are moving fast in Washington, and proposed legislation may be before the Senate as early as April. We continue to participate in Senator Kent Conrad's Medicare Payment Task Force, which will conclude soon with recommendations on Medicare payment reform.

The 2009 ND Legislative Assembly as this edition of *Checkup* goes to print is moving toward the deadline for bills to be acted on in the second chamber, after which conference committees will bring the session to conclusion sometime before April 30.

A special thanks to all physicians who provided coverage to the NDMA Doctor of the Day program at the capitol. The program is popular with legislators, providing needed consultation and services and giving the visiting physician an interesting legislative experience. Many physicians have participated, and we appreciate the standing coverage on Wednesdays provided by the Bismarck Center for Family Medicine.

#### *Medicine's State Legislative Agenda*

Last year, the NDMA Commission on Legislation, chaired by Dale Klein, MD, recommended policy priorities and worked with members to refine the agenda prior to the session and take positions on other bills as they were introduced. NDMA priorities include rebasing Medicaid physician payments to cost, imposing fair contract standards on commercial health insurance companies, supporting initiatives that strengthen the UND School of Medicine & Health Science as well as our residency programs, protecting our medical liability reforms including the current cap on non-economic damages, addressing minor consent issues with prenatal and other pregnancy-related care, opposing inappropriate expansions of allied professional scope of practice including psychologist prescribing, protecting and improving the physician practice environment, improving the health of

the public, and much more.

The NDMA website at [www.ndmed.org](http://www.ndmed.org) provides legislative news, hearing schedules and bill summaries, all linked to the Legislative Assembly bill status system. NDMA also provides policy updates throughout the year by e-mail through the *e-Checkup*. Please call the NDMA office or drop us an e-mail at [staff@ndmed.com](mailto:staff@ndmed.com) if you would like receive the *e-Checkup*.

#### *Medicine's Response to Bad Bills*

In addition to pursuing our agenda, several bills were defeated as a result of our advocacy efforts. A full court press was necessary to defeat HB 1390, which would have removed the \$500,000 cap on non-economic damages in lawsuits against health care providers which has been in place since 1995. The vote was 31-63. A minority report proposing an alternative of raising the cap to \$1 million was also defeated 42-52. Medical liability issues are difficult and complex; yet legislators clearly understood in the end the importance of the cap and what it means to our medical liability climate and recruitment/retention issues here in North Dakota.

Other bills we helped defeat include HB 1488, which would have allowed a "medical psychologist" to prescribe medications "customarily used in the diagnosis, treatment, and management of an individual with a psychiatric, a mental, a cognitive, a nervous, an emotional, or a behavioral disorder." Psychologist prescribing bills have been defeated in twenty states over the past years. Psychologists – who are not medically trained and who are not physicians – are not qualified to prescribe psychotropic medications. Several other bills were defeated that were deemed contrary to the best interests of medicine.

#### *Medicaid Rebase Tops 2009 Medicaid Issues*

NDMA has testified in appropriations committees on the need for an equitable rebase of physician Medicaid payments. Last session, NDMA and NDHA shepherded legislation through that appropriated dollars for the Department of Human Services to hire consultants to develop methodologies for determining what it would take for Medicaid to rebase physician, hospital, and other traditional Medicaid providers to cost. The consultant, The Public Consulting Group, concluded that physicians currently are receiving only 51% of what it costs to provide medical care to Medicaid patients.

We testified that Medicaid patients receive care from a North Dakota health care system that is recognized nationally as a high-quality, efficient health care system. However, we have unique healthcare workforce recruitment and retention challenges occurring in our state that are driven by our demographics, payor reimbursement policies and other practice issues. Our capital needs continue to grow, with aging facilities, technology and equipment – we have the oldest age of plant in the country. Our costs for medical equipment, new technology and supplies continue to increase.

In addition, we suggested that across the board, we are a “poor payor state.” The commercial market through Blue-Cross BlueShield of North Dakota pays for medical and hospital services at levels considerably less in North Dakota than by commercial insurers in other states in our region. In Medicare, there is substantial *geographic disparity* in patient services and physician reimbursement levels which is having an increasingly negative impact on patient care and access in North Dakota.

In NDMA written testimony, we stated “As physicians, we are very concerned that this continuing trend of poor payment does not bode well for the future of health care in North Dakota, and in time the access and quality in health care enjoyed in the state will deteriorate rapidly as health care resources become increasingly scarce and health care work-force and capital needs are not met. We are working on all these avenues that provide resources to sustain our health care system. We suggest that the Medicaid program must do its part to ensure fair payment for the actual cost of medical care received by its Medicaid patients, just as commercial insurers and the federal government must do their part.”

A rebase at 100% of what the consultant said it would take to bring physician payments to actual cost would cost an additional \$14,699,550 in general funds for the biennium, in addition to the \$4,899,850 already budgeted. At this level, physician payments would rebase from 51% to about 100% of cost.

Our ask: The North Dakota Medical Association supports the Governor’s budget and the proposed increase that brings payment for physician services closer to cost (64% of cost). However, to rebase at less than cost only continues a pattern of inequitable payment that will continue to hinder our ability to maintain a health care system in our state that provides higher quality at less cost than most other states in the country.

The bill, HB No. 1012, the appropriations bill for the Department of Human Services, would appropriate \$4,899,850 in state general funds (\$13,250,000 in total state and federal funds) to rebase Medicaid physician payments closer to actual cost. Physicians would receive a 20.66% increase in the first year of the 2009-11 biennium (% change from the 2007-09 appropriation). The bill would also appropriate \$8,140,450 in general funds (\$22,013,114 in total state and federal funds) to rebase Medicaid hospital payments to 100% of actual cost. Hospitals would receive a 14.05% increase in the first year. Both physician and hospital payments would be increased by 7% in the second year of the 2009-11 biennium.

The DHS budget bill continues to make its way through the process, currently in the Senate Appropriations Committee.

#### *Public Health Initiatives*

The ND Society of Eye Physicians and Surgeons along with NDMA have again raised the issue of the toll taken each year

by bottle rocket injuries. SB 2366 introduced by Sen. Dave Oelke would prohibit the sale of small bottle rockets, which are inherently dangerous and erratic. The bill passed the Senate and is currently being considered in the House.

NDMA also supports SB 2063 which would implement Measure 3 approved by ND voters this past November, establishing a comprehensive tobacco prevention and control program for the state. Recently, Dale Klein, MD, of Mandan was appointed by Governor John Hoeven to serve on the comprehensive tobacco control advisory committee established by the initiated measure. NDMA also supported HB 1213 which would expand the state’s smoke-free workplace law to bars and motels and hotels; however, the bill was defeated.

#### *Minor Consent Again Considered*

SB No. 2394 as introduced for the third time by Senator Karen Krebsbach on behalf of NDMA, would allow a physician to rely on the consent of a minor for pregnancy testing, prenatal care and pain management related to pregnancy. This issue has been controversial in the past, particularly in the House where concerns over maintaining parental control have trumped legitimate concerns over the welfare of the pregnant minor and her unborn child. The Senate passed versions of the bill in both 2005 and 2007. The Senate passed SB 2394, and it is currently being considered in the House.

#### *Medical School Bills Address Performance Audit; Executive Budget Excludes Some Initiatives*

SB 2003 is the appropriation bill for the North Dakota University System which includes funding for the UND School of Medicine & Health Sciences. The bill includes a base level general fund appropriation of \$34,027,701 with enhancements of \$5,905,174 for a total general fund appropriation of \$39,932,875 for the 2009-11 biennium. The bill also includes one-time funding projects that include an electronic medical records system for UNDSMHS (\$225,000). There are several additional budget requests approved by the State Board of Higher Education that were not included in the Governor’s budget, including:

- College affordability funding to limit tuition increases (\$767,427).
- Funding for planning, land acquisition, and construction of a new facility for the Bismarck Center for Family Medicine (over \$5 million).
- Funding to retire the bond debt of the Minot Center for Family Medicine (\$4 million).
- Establishment of an enhanced geriatrics training and care delivery program (\$1,074,450).
- Establishment of an MPH degree program (\$1,133,600), and development of a comprehensive health care delivery plan for ND (\$707,850).

The University System budget is currently being considered in the House. In addition, three bills were introduced by the State Board of Higher Education as a result of action by the Medical Center Advisory Council of in response to the UNDSMHS performance audit. NDMA supports all three bills.

First, SB No. 2079 which has passed both the Senate and House would revise the statutory purpose of the UND School of Medicine & Health Sciences and also change statutory references to the UND "State Medical Center" to the "UND School of Medicine & Health Sciences." The second bill, SB 2081, would revise the name and duties of the State Medical Center Advisory Council, changing the name to the UND School of Medicine & Health Sciences Advisory Council and requiring the Advisory Council to advise UND officials and the State Board of Higher Education regarding school of medicine plans, programs and facilities. The bill would also require the Advisory Council, in consultation with the medical school and other entities represented on the Council to study and make recommendations regarding UNDSMHS strategic plans, programs and facilities. The Advisory Council would be required to submit a biennial report to the entities represented on the Council and the ND Legislative Council, which would be required to include recommendations for implementing strategies for addressing the health care needs of the people of the state and information regarding the state's health care workforce needs. This bill has also been passed in both the Senate and House.

Finally, SB 2077 would revise the current UNDSMHS student loan fund as recommended in the UNDSMHS performance audit. The bill would create a revolving loan fund and increase the amount of an allowable loan from \$6,000 to \$10,000, as well as make other technical changes in the loan fund statutes.

#### *Dozens of Workers Compensation Bills Addressed*

The Industry, Business & Labor committees of both chambers are busy with workers compensation bills addressing structural reform and performance, benefits, and WSI presumptions and procedures. NDMA supports HB 1561 which would require WSI to give controlling weight to the injured employee's treating doctor's opinion if the doctor's opinion on the issues of the nature and severity of the injured employee's medical condition is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the injured employee's record. The bill passed the House. NDMA is closely monitoring all WSI bills, and weighing in as appropriate on behalf of physician interests.

Much more is occurring at the state capitol and in Washington, D.C. These are interesting times and there will be interesting new proposed "solutions" to health care issues. Each physician needs to play an active part in shaping the future. Our state NDAFP and NDMA provide the best means to act as one voice.

## **2009 NDAFP Annual Meeting**

The 54th Annual Meeting and Scientific Assembly of the North Dakota Academy of Family Physicians will be held on **June 18-19, 2009 in Bismarck, ND**. All Active, life, resident and student members along with other medical professionals are invited to attend. This will be an excellent opportunity to combine quality CME with enjoyable family time.

A block of rooms has been reserved at the Ramkota Hotel, in Bismarck. The rate is \$74 per night. The release date for the room block is 5/19/2009. To make reservations please call 701-258-7700. After the release date reservations will be taken on a space available basis.

This activity will be submitted for 9.0 prescribed credits to the American Academy of Family Physicians.

### **Tentative Agenda:**

(all times listed in Central Time)

#### **Thursday, June 18th**

- 8:00 am NDAFP Foundation Board Meeting
- 9:00 am NDAFP Board of Directors Meeting
- 12:00 pm Registration/Lunch/Exhibit Hall Open
- 1:00 pm - 5:00pm CME Lectures  
Topics to include Vitamin D, Gynecology Update, and Orthopedics
- 5:30 pm Transfer to Riverboat Dock
- 6:00 pm Riverboat Dinner Cruise

#### **Friday, June 19th**

- 7:00 am Continental Breakfast  
Past President's Breakfast
- 8:00 am - 12:00 pm CME Lectures  
Topics to include Pediatrics, Radiology and Medical Home
- 12:00 pm Annual Business Meeting Luncheon
- 1:30 pm - 4:30 pm CME Lectures  
Topics to include Dermatology, Library Resources, and Pain Mgmt

### **Remember your donation items for the Annual NDAFP Foundation Silent Auction.**

**We welcome AAFP Board Member  
Dr. Kenneth Bertka, M.D., Holland, OH  
as the installing officer of this meeting.**

Registration is now available on the NDAFP website:  
<http://www.ndafp.org>



## 2009 Match Results

NAME/ LOCATION	PROGRAM
Ament, Emily U of California (San Francisco) /Fresno Program—Fresno, CA Kern Medical Center Program Bakersfield, CA	SURGERY/PRELIM (Year 01) EMERGENCY MEDICINE
Bradfield, Lavone Orlando Regional Healthcare Program - Orlando, FL	INTERNAL MEDICINE
Breker, Dane UNDSMHS – Fargo, ND U of Michigan Prog.—Ann Arbor	TRANSITIONAL NEUROLOGY
Christianson, Mathias Synergy Medical Education Alliance/Michigan State Univ. Prog. – Saginaw, MI	EMERGENCY MEDICINE
Cooper, Jeffrey Mayo School of Graduate Medical Education Program – Rochester, MN	PEDIATRICS
Cornatzer, Eric U of Alabama Medical Center Prog. – Birmingham, AL	INTERNAL MEDICINE
Cote, Derrick U of Kansas School of Medicine Wichita, KS	ORTHOPAEDIC SURGERY
DeFoe, Adam UNDSMHS—Fargo, ND	TRANSITIONAL
Dendy, Khalin Mayo School of Graduate Medical Education Program - Rochester, MN	INTERNAL MEDICINE
DePompolo, Anna U of Minnesota Medical School Minneapolis, MN	PEDIATRICS
Duchsherer, Nichole U of New Mexico School of Medicine – Albuquerque, NM	PATHOLOGY
Dvorak, Stephanie Medical College of Wisconsin Affiliated Hospitals Program - Milwaukee, WI	OBSTETRICS & GYNECOLOGY
Eickenbrock, Andrea Maricopa Medical Center	OBSTETRICS &

Phoenix Integrated Residency Program – Phoenix, AZ	GYNECOLOGY
Falcon, Gilbert UNDSMHS—Minot, ND	FAMILY MEDICINE
Foertsch, Kayla UNDSMHS—Grand Forks, ND	SURGERY /GENERAL
Franklund, Rebecca Texas Tech University (Amarillo) Program – Amarillo, TX	OBSTETRICS & GYNECOLOGY
French, Kris U of Utah Program/Affiliated Hospitals – Salt Lake City, UT	NEUROLOGY
Gasparini, Andrew Altru Health System Grand Forks, ND	FAMILY MEDICINE
Gravning, Stephanie U of Nebraska Medical Center College of Medicine Prog. Omaha, NE	INTERNAL MEDICINE
Grosz, Kenneth U of Nebraska Medical Center College of Medicine Prog. Omaha, NE	EMERGENCY MEDICINE
Guido, Jenny U of South Florida College of Medicine Program - Tampa, FL	SURGERY – GENERAL
Hager, Jake UNDSMHS –Fargo, ND	INTERNAL MEDICINE
Hendrex, Douglas U of Arkansas for Medical Sciences AHEC Prog. Fort Smith, AR	FAMILY MEDICINE
Holmes, Janalee UNDSMHS - Grand Forks, ND	SURGERY-GENERAL
Horner, John Rapid City Regional Hospital Program – Rapid City, SD	FAMILY MEDICINE
Huff, Jenna Akron General Medical Center /NEOUCOM Prog.-Akron,OH	OBSTETRICS & GYNECOLOGY
Johnson, Stefan UNDSMHS - Grand Forks, ND	SURGERY-GENERAL

**Julius, Kristin**  
George Washington School of  
Medicine – Washington, D.C.      **INTERNAL  
MEDICINE**

**Kimball, Jacquelyn**  
U of Connecticut Health Center/  
John Dempsey Hospital  
Farmington, CT      **PSYCHIATRY**

**Kohoutek, Bradley**  
UNDSMHS - Fargo, ND      **PSYCHIATRY**

**Kolberg, Jon**  
Altru Health System  
Grand Forks, ND      **FAMILY MEDICINE**

**Leingang, Brett**  
Grand Rapids Medical Education  
and Research Center/Michigan  
State University Program  
Grand Rapids, MI      **PEDIATRICS**

**Lessard, Collette**  
Mayo School of Graduate  
Medical Education Program  
Rochester, MN      **OBSTETRICS &  
GYNECOLOGY**

**Longmuir, Mark**  
UNDSMHS - Minot, ND      **FAMILY MEDICINE**

**Maarouf, Jamal**  
St. Louis U School of Medicine  
Program – St. Louis, MO      **NEUROLOGY**

**Marek, Ashley**  
Hennepin County Medical Center  
Minneapolis, MN      **SURGERY –  
GENERAL**

**McCoy, Austin**  
U of Florida College of Medicine  
Shands Jacksonville Medical Ctr  
Jacksonville, FL      **INTERNAL  
MEDICINE**

**Mees, Sara**  
Altru Health System  
Grand Forks, ND      **FAMILY MEDICINE**

**Milanovich, Nicholas**  
U of Pittsburgh Medical Center  
Medical Education (Presbyterian  
Shadyside Hospital) Program  
Pittsburgh, PA      **TRANSITIONAL**

**U of Pittsburgh Medical Center  
Medical Education Prog.  
Pittsburgh, PA      **RADIOLOGY –  
DIAGNOSTIC****

**Miller, James**  
UNDSMHS - Fargo, ND      **TRANSITIONAL**  
U of Iowa Hospitals & Clinics  
Program – Iowa City, IA      **RADIOLOGY –  
DIAGNOSTIC**

**Pearce, Jean**  
U of California (Davis) Health  
System Program - Sacramento, CA      **PEDIATRICS**

**Rameden, Rebecca**  
U of Iowa Hospitals & Clinics  
Program – Iowa City, IA      **MED-PRELIM/  
NEUROLOGY**

**U of Iowa Hospitals & Clinics  
Program – Iowa City, IA      **NEUROLOGY****

**Ranum, Carrie**  
Grand Rapids Medical Education  
and Research Center/ Michigan  
State U Program—Grand Rapids, MI      **PEDIATRICS**

**Rau, Brian**  
U of South Florida College of  
Medicine Program - Tampa, FL      **RADIOLOGY –  
DIAGNOSTIC**

**Reindl, Alisa**  
Sioux Falls Family Medicine Prog.  
Sioux Falls, SD      **FAMILY MEDICINE**

**Reinke, Sara**  
U of Nebraska Medical Center  
College of Medicine/Creighton  
University Program – Omaha, NE      **PEDIATRICS**

**Richards, Melissa**  
Mayo School of Graduate  
Medical Education Program  
Rochester, MN      **OBSTETRICS &  
GYNECOLOGY**

**Saur, Nicole**  
Tufts-New England Medical  
Center Program – Boston, MA      **SURGERY –  
GENERAL**

**Schaetzel, Shaina**  
Medical College of Wisconsin  
Affiliated Hospitals Program  
Milwaukee, WI      **SURGERY –  
GENERAL**

**Schmidt, Steven**  
U of Nebraska Medical Center  
College of Medicine Prog.  
Omaha, NE      **EMERGENCY  
MEDICINE**

**Seitz, Jolyn**  
St. Joseph Mercy Hospital Prog.  
Ann Arbor, MI      **OBSTETRICS &  
GYNECOLOGY**

**Sickler, Benjamin**  
U of Utah Program - Salt Lake  
City, UT      **MEDICINE/  
PRELIMINARY**

**Oregon Health & Science U Prog  
Portland, OR      **ANESTHESIOLOGY****

**Soule, Matthew**  
 Dartmouth-Hitchcock Medical Center Program – Lebanon, NH    **SURGERY – GENERAL**

**Speidel, Brandon**  
 UNDSMHS - Fargo, ND    **TRANSITIONAL RADIOLOGY – DIAGNOSTIC**  
 U of Nebraska Medical Center College of Medicine Prog. Omaha, NE

**Steppler, Shannon**  
 U of Utah Program-Salt Lake City    **PEDIATRICS**

**Sullivan, Kevin**  
 U of New Mexico School of Medicine, U of New Mexico Hospital – Albuquerque, NM    **ANESTHESIOLOGY**

**Upton, Marisa**  
 UNDSMHS - Minot, ND    **FAMILY MEDICINE**

**Williams, Travis**  
 U of Iowa Hospitals & Clinics Program – Iowa City, IA    **INTERNAL MEDICINE**

**Wiltse, Richard**  
 Naval Medical Center San Diego, CA    **SURGERY – GENERAL**

**GRADUATES:**

**Dahl, Brian**  
 Southern Illinois U School of Medicine Memorial Medical Ctr Springfield, IL    **ORTHOPAEDIC SURGERY**

**Scaffer, Andrew**  
 William Beaumont Hospital Program – Royal Oak, MI    **SURGERY – GENERAL (PGY-2)**

**Strand, Megan**  
 U of New Mexico Albuquerque, New Mexico    **DERMATOLOGY**

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## Family Medicine Quarterly

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