NORTH DAKOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR NORTH DAKOTA

Family Medicine Quarterly

Volume 35, No. 3 **Winter 2009**

TABLE OF CONTENTS:

Issues In This Issue

Roger W. Schauer, MD

Change is a major theme for this Winter issue of the FMQ. In his **Update** Rob Beattie shares **changes** Congress already has made to the ***"Patient Protection and Affordable Care Act"***, and references an AAFP website that addresses some of these changes. NDAFP President Richard Vetter begins his column by describing "**Change"** as the new normal. Dr. Vetter lists the principles defined by AAFP to help focus health care reform discussion, and highlights some **Patient Centered Medical Home (PCMH)** challenges. The **PCMH** theme was also noted by Dr. Kimberly Krohn in her President's address to the House of Delegates at the NDMA meeting in Bismarck in September. In her address Dr. Krohn challenged us to "….skate where the puck will be…." (She might be referencing a certain winter sports hero). But with less than two weeks until the holiday recess for Congress we are yet uncertain "where the puck will be" for a number of issues. In that address (partially reprinted by Mr. Bruce Levi in his article **Working the Policy Process)** Dr. Krohn elegantly highlighted some tasks, transitions, and transformations we face in the near future. Bruce also informs us of the NDMA activities on our behalf, and encourages us to be **proactive** rather than "sit on the sidelines" as **changes** are occurring in health care.

In his article, **"Family Medicine in Turkmenistan: past, present and perspectives of USA-Turkmenistan partnership",** Dr. Orazklychev Orazklych, from Ashgabat, Turkmenistan, informs us of **changes** in **health care** in his country. During the ten months he was a visiting Fulbright Scholar in our Department of Family and Community Medicine Dr. Oraz , as he asked us to call him, talked about his challenge, which is to introduce Family Medicine into the Turkmenistan medical school in Ashgabat. Dr. Oraz acknowledges the support his country has received from North Dakota physicians over the past 14 years in this on-going process. Dr. Oraz's comments about health care in his country reminded me of the description of physicians' training in the Soviet Union in the middle of the last century, as described by Alexander Solzhenitsyn in his book, *"Cancer Ward"*. Dr. Oraz's article is an informative and interesting read. We needed to limit the length of the article, so further definition of Family Medicine Residency training in Turkmenistan was not reprinted. If anyone is interested in that material, please request his full article from Brandy or myself.

The article titled "**Information Technology and Teaching in the Office: Advance Directives"** is reprinted by permission of *"The Teaching Physician*. In a sense, it also suggests **change** – access to on-line information and tools that we and our patients will be using in the near future – change that will be part of the new **Patient Centered Medical Home**.

Finally, learning opportunities are available in the upcoming **Big Sky Conference in Montana** and the **Dakota Conference on Rural and Public Health**. The latter will be at the Grand Forks Alerus Center April 13-15, 2010. Dr. Robert Kelley, now in his second year as president of UND, will be one of the plenary speakers as we address **Health Care in Transition: Creative Strategies**. Dr Kelley has long talked about **collaboration** (see Rich Vetter's reference to team work).

Department of Family and Community Medicine Update

Robert Beattie, MD

The scene today opens with the Senate debating the Patient Protection and Affordable Care Act. Amendments are being offered and voted on. The Academy of Family Physicians has been watching closely.
In a letter to Senator Reid, Dr. Ted Epperly, chair of the AAFP board, said, "The *Patient Protection and Affordable Care Act…* is a valuable part of the process to reach the goal of health care coverage for everyone and contains some valuable investments in transforming our health care system to one based on primary care." He continues, "There are several concerns that family physicians have with the legislation that you have introduced. AAFP believes that the Senate must act to repeal the flawed Medicare Sustainable Growth Rate and replace it with a better, fairer, and more predictable system of updating physician payments…" Dr. Epperly concludes, "We will have other suggestions for improvement in the days ahead, but the need for health reform is urgent and the Senate should respond accordingly."

The AAFP details the pros and cons of the bill and I submit for your review an excerpt from the document post on their web site. http://www.aafp.org/online/en/home/policy/federal/reform09.html

A number of provisions which AAFP had supported were dropped from the Patient Protection and Affordable Care Act including:

The provision to end the health and medical liability insurance industry antitrust exemptions in order to make health and malpractice insurers accountable under antitrust laws that ban price-fixing, bid rigging and dividing markets between them.

The provision to reinstate the student loan deferment program known as the 20/220 pathway which allowed for the deferment of interest and principal payments on educational loans during residency based on a defined debt-to-income ratio.

The Senate leadership's bill did make two changes that AAFP asked for:

The bill eliminates the provision that physician payment would be reduced by 5 percent if the physician's resource use was at or above the 90th percentile of national utilization.

The PQRI penalties remain in the bill, but their effective date has been pushed back two years to 2015.

Compared to the House bill, the Senate is missing a number of significant provisions:

Primary care bonus payment, while lower in the House bill, is permanent and the threshold is lower as well.

The Senate bill does not have the House bill's Increased payment for primary care in Medicaid and mandated coverage of preventive services, along with the elimination of cost-sharing for preventive services

The House bill expands Medicaid enrollment to 150 percent of the Federal Poverty Level (FPL) compared to 133 percent in the Senate bill.

Codifying Medicaid payment for GME is missing in the Senate bill.

The deliberation over health care reform continues. If you have strong feelings, this is your opportunity to be engaged in the process. I encourage you to contact our Senators with your comments and concerns. Senator Conrad, 202-224-0581 and Senator Dorgan, 202-224-2551

Message from the NDAFP President

Richard Vetter, MD

Change. This seems to be the new normal. Change in leadership in Washington. Change in leadership at the medical school at UNDSMHS. New leadership at BCBSND. Merger of Sanford and Meritcare. While this past year has seen significant change, more appears to be on the way.

As the debate on health care reform continues. It is hard to imagine that there will not be at least some major changes to the financing and delivery of health care. While this change can create excitement, it also creates a significant amount of anxiety. It should be reassuring to know that your academy has been working tirelessly on our behalf. The AAFP believes that the key to designing a new improved health care system is to emphasize the importance of primary care. The following core principles are being used in advocacy efforts:

1. Ensuring health care coverage for all and aligning financial incentives to support this system
2. Increasing payment for primary care services that emphasize a blended payment formula
3. Redesigning the manner of primary care delivery modeled on a Patient Centered Medical Home (PCMH)
4. Reinvigorating medical student interest
5. Making sure we have an adequate primary care workforce
6. Continuing to emphasize the importance of medical liability tort reform
7. Educating around the necessity of administrative simplification and decreasing the paperwork burden
8. Advocating for insurance system reform

These challenges will require that we also change in the way we deliver care for our patients. We will need to learn to delegate some duties to our team members in our PCMH. We will need to embrace the electronic age (EMR's, E-prescribing etc). We have to be creative and supportive in our educating of medical students. We have to work with new professionals (hospitalists, midlevels etc). We will have to give up some old habits and be open to trying new ones.

Change is necessary to bring new ideas and a fresh approach to problem solving. In this way we can improve the health of our patients and communities we serve. Isn't this the reason we chose this profession in the first place?

Executive Excerpt

Brandy Jo Frei

Merry Christmas Everyone-

It is a very busy time for everyone and I hope we all take the time to enjoy our family, reflect on the year that has been, and plan for the year ahead.

The new year will be a busy one for the NDAFP. We will have a wrap up of our Fall CME that was held on December 12th. We will hold the 33rd Anniversary of the Family Medicine Update Conference in Big Sky, MT on January 18-22. There will be a board meeting conference call, review of all committees, and preparation of the 2010 budget. With low numbers preregistered for the Big Sky Conference, we may have some financial changes in the new year. The spring will be a busy time for planning the Annual Meeting that will be held July 15-17 in Medora, ND. I may also have to schedule a few days off in June as I am due with our 3rd child. The Frei family is very excited about this new addition. The Fall will be filled with an ALSO course in Minot Sept. 16-18, another successful Fall CME event with dates yet to be determined and another round of committee conference calls.

Thank you in advance for your patience and understanding during the busy months to come. I wish you all a very Happy Holiday season, safe travels, and a renewed outlook at the great year to come. Please do not hesitate to contact me with any questions or concerns that you have and I hope one of your resolutions is to get more involved in the NDAFP. We hope to do lots of great things in the years to come. Thank you.

NORTH DAKOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR NORTH DAKOTA

NDAFP, Brandy Jo Frei
501 N Columbia Rd
Grand Forks, ND 58203
Brandy@ndafp.org
701-772-1730 phone
701-777-3849 (fax)

Working the Policy Process

Bruce Levi, JD, NDMA Executive Director

As we move into December of an odd-numbered year, the only solace we have is that the ND Legislative Assembly will not be meeting in 2010; yet this is likely one of the more intense periods of public debate on health care we've ever seen.

Dr. Krohn Is New NDMA President

As the new President of NDMA, **Kimberly Krohn** takes the reins at a time of unprecedented scrutiny of our health-care delivery system. In her address to the NDMA House of Delegates in September, Dr. Krohn highlighted the need to "transform medical practice one physician at a time," in providing intelligent, thoughtful leadership in a time of change while "skating to where the puck will be" as far as our clinical systems and elements of care are concerned. As an organization, NDMA can provide support for these transformations. Dr. Krohn said that physicians will need to be open-minded about the essential components of clinical care now and in the future, maintaining the patient as the focus of our clinical systems:

Health information technology for greater communication between doctors, reduction of duplication, and data gathering to monitor quality indicators.

Prospective chronic disease management.

Transformation of communication systems with patients.

Transformation of outpatient clinic scheduling to enhance access.

Medical information at the point of care.

Reflective practice that looks at outcomes, not just process

Change in the structure of practices and practice procedures:

Eliminating waiting rooms physically and by making them obsolete.

Exploring group visits, e-visits, etc.

Exploring lifestyle balance.

Maintaining relevance in medical knowledge and practice, whether by maintenance of certification or other means

Leadership knowledge and development in order to guide teams to develop programs/structures to best care for our communities

At the NDMA annual meeting, several important resolutions were adopted that will guide our policy efforts in the coming weeks and months including a ten-page resolution on Medicare payment and health system delivery reform, and resolutions relating to family medicine residency positions, development of a state health information technology plan, support for the state tobacco prevention and control plan, and others. All of these resolutions are on the NDMA website at www.ndmed.com.

Moving Toward An End Game on Health System Reform

With national health care reform being debated in Congress, our goal over these past many months has been to "stay in the game" so to speak, continuing to work very closely with our ND Congressional Delegation on Medicare payment and health system reform issues as we have since the spring of 2008. Our Delegation has been working within an atypical Congressional process working to keep the best interests of ND patients, physicians and our health care system at the forefront – working to ensure that geographic inequity is replaced by quality and cost efficiency as the basis for incentives in the Medicare payment system and that new models for health system delivery recognize our strengths in North Dakota or provide new resources for areas needing improvement. This includes support for physician-led, patient-centered medical homes to improve care coordination and increased new funding for services provided by primary care physicians.

Our various national and state specialty societies, the AMA and other physician organizations have taken varying strategic positions as this process has continued to move forward – as we now are essentially down to two bills in Congress, HR 3692 which was passed narrowly by the House along with a companion bill, HR 3961, which would provide a "permanent" fix to the Medicare physician SGR formula, and HR 3590 which is presently being debated in the Senate.

I often hear physicians express concerns about many of the strategic positions being taken by one or more of their physician groups, or concerns about our physician organizations occasionally standing up and supporting the position of one member of our Delegation or another (e.g., opposing a public option at Medicare rates) even though there are many items in the legislation we continue to oppose as well as items we support. Quitting your organizations or advocating that our Delegation sit on the sidelines rather than actively engage to improve the legislation does not recognize the reality of what it

takes to effectively lobby, in my view, and accomplish a good legislative product for a vote as an end game to the political process. The legislation may fail in the end, or not be supportable depending on the final package, but it is important to stay in the process and assist those who represent North Dakota and continue to advocate for what's best for North Dakota physicians and patients.

In the coming weeks, NDMA will continue to e-mail updates on health system reform, including the various positions taken on legislative provisions. There are updates and many resources online at the NDMA website at www.ndmed.com, including all our public statements, testimony, bill comparisons and other information relating to health system reform at both the federal and state level.

If and when national health system reform is enacted by Congress and signed by the President, we in North Dakota will need to make many decisions about our state's participation in the many reform opportunities that will become available, whether it be new Medicaid state benefit options for service delivery or any of the many pilot projects or demonstration programs relating to health system delivery, prevention and wellness and new payment systems. At the same time, your NDMA along with hospitals have been in discussions with CMS, HRSA and offices of our Congressional Delegation for several months, talking about North Dakota's strengths in providing high quality, cost-efficient care and how our state could become a national model for looking at a statewide system of quality care delivery. These discussions will continue in the coming months and our commitment to this process will continue as we learn more about what incentives might be brought to the table either through legislation or administratively through CMS demonstration authority.

Working State Issues

While 2010 is our year of preparation for the 2011 ND legislative session, the state's interim committee process is a very active one for healthcare. In my previous FMQ article, I highlighted the many interim studies, including studies by the ND Legislative Council's interim Industry, Business & Labor Committee, Health & Human Services Committee and other committees focusing on unmet health care needs, access to psychiatric services and mental health commitment procedures, factors impacting the cost of health insurance, the needs of pregnant minors and whether additional education and social services would enhance the potential for a health child and a positive impact for the minor, consideration of workers compensation laws with respect to prior injuries, preexisting conditions and degenerative conditions, and others.

Many of these studies are important to NDAFP and your practice – we continue to put our testimony and other documents on the NDMA website and work with our physician leadership and organizations as necessary to ensure that physicians are well represented in the interim. The interim IB&L Committee has been particularly active in focusing in on federal health reform implications for North Dakota, and will meet for the fourth time on January 7 at the UND School of Medicine.

Other activities are ongoing as well. The process for determining the location of the Bismarck Center for Family Medicine continues, in implementing the appropriation of $5.4 million provided by the 2009 ND Legislative Assembly. The new ND Health Information Technology Advisory Committee established by the legislature is working on leveraging federal funds. The State Health Information Exchange Cooperative Agreement Program grant application was submitted on November 15 for $5.34 million. In anticipation of the receipt of the grant, a request for proposal was issued for strategic and operational planning services. NDMA is establishing a "clinical workgroup" to assist in advising the committee work and the new state HIT office as we work to develop a health information exchange function for our state. Please call the NDMA office if you are interested in participating on the HIT clinical workgroup. There is also an effort ongoing to obtain federal funding for an HIT Regional Extension Center.

As the work continues, your help in supporting NDAFP and your state medical society are critical in ensuring we have the resources and expertise to continue to be successful. I strongly encourage you to join or rejoin NDMA in 2010 along with your family medicine colleagues who see the value of our continuing to work together on policy issues. Your NDMA dues help support our efforts to, in turn, assist the NDAFP.

Best wishes for the new year!

Family Medicine in Turkmenistan: past, present and perspectives of USA-Turkmenistan partnership.

Dr. Orazklychev Orazklych, Fulbright Exchange Scholar, Turkmenistan

Reforming the system of Primary Health Care is an urgent need for countries of Eastern Europe and the Central Asia, where Family Medicine is a new phenomenon as a specialty and a discipline. Over the last years in these countries, including Turkmenistan, national models of Family Medicine are being created. These models contain not only social and cultural features, but also national peculiarities of Health Care System of every country.

Turkmenistan, a new independent country in Central Asia, gained its independency in October 1991 after breaking down of the former Soviet Union. Introduction of Family Medicine in Turkmenistan began in January 1, 1996 according to the National Program "Health" initiated by President of Turkmenistan. The overarching goal of this program was overall improvement in the efficiency and management of Health Care System in Turkmenistan. It was noted, that former Soviet Health Care System with unnecessary excess of hospitals and more specialized service in the level of Primary Care was inefficient for new independent country and radical reforms were needed. Particularly attention was paid to Primary Health Care System. Experience of Family Medicine in Primary Health Care System of developed countries served as a basis for introducing Family Medicine in Turkmenistan. The former district internists and pediatricians as well as physicians of other specialties had to be retrained for becoming family physicians. However it was a big challenge, because we did not have any experience in the field of Family Medicine, particularly in training family physicians. Since those days the study of the international experience, especially the experience of developed countries such as the USA, Canada, UK and etc. was very important for our country.

I am proud to draw the attention, that precisely 1996 was the starting point of collaborating in Family Medicine between Turkmenistan and the USA and in particular University of North Dakota as well as University of Connecticut was the main US partners with Turkmenistan. The partnership supported by the United States Agency for International Development (USAID) and the American International Health Alliance (AIHA). The partnership's overall goal was to strengthen the Primary Health Care System in Turkmenistan by developing a skills-based primary care curriculum and retraining program for physicians, nurses, and physician assistants (feldshers). North Dakota partners included University of North Dakota and North Dakota State Health Department with North Dakota Primary Health Care Consortium, which also included Center for Family Medicine and St Alexius Medical Center in Bismarck, West River Regional Medical Center in Hettinger and North Dakota Association of Community Health Centers. After intensive five-week training of future trainers in North Dakota clinical settings and providing latest equipment, the Family Medicine Training Center in Ashgabat, Turkmenistan officially opened on May 14, 2001. The unique four-week curriculum was jointly developed by North Dakota and Turkmen partners and focuses on skills training in assessment, diagnosis, treatment and monitoring as well as on health promotion and illness prevention in clinical and home settings. The training program, which emphasizes a team approach within the practice setting, now is being carried out by qualified Turkmen physician-nurse instructor teams who have initially undergone basic and advanced training provided by the North Dakota partners in North Dakota and Ashgabat. The unique future of this program is its team approach to care, which trains physician-nurse teams, who work together to provide care. Physicians and nurses study the same topics together in the same groups. Training modules cover main topics in Otolaryngology, Ophthalmology, Cardiovascular diseases, women's and children's health and facility has been equipped with special classrooms for each topic areas. In 2003 partners from Department of Family and Community Medicine UND School of Medicine and Health Sciences assisted their partners in Ashgabat with the development of a new module on women's health that was been added to the curricula of the Family Medicine Training Center. In September 2003, top-level administrators from the Ministry of Health Care and Medical Industry of Turkmenistan traveled to North Dakota visiting hospitals, family practice sites and UND School of Medicine. The visitors got first-hand information about healthcare financing and insurance systems, reviewed nursing and MD curriculum and discussed UND medical education system with students and residents.

Another USA-Turkmenistan partnership has been between Department of Family Medicine of University of Connecticut School of Medicine and Department of Family Medicine of Turkmen State Medical Institute. During several visits by US partners to Turkmenistan and Turkmen partners to University of Connecticut with support from USAID and AIHA has been learned organization of providing medical care by family physicians and the training of family physicians in the

USA including pre-diploma and post-diploma education, and development of curricula for continuous medical education. As part of this partnership exchange program Turkmen specialists had an opportunity to visit Office of American Academy of Family Physicians in Kansas-City. In December 2005 thanks to continued support and assistance by USAID and AIHA a second Family Medicine Training Center in Ashgabat was established with the aim of providing training to the healthcare practitioners from rural areas of Turkmenistan.

As a continuation of strong partnership between North Dakota and Turkmenistan from September 1, 2008 until June 30, 2009 as a Fulbright visiting scholar, I had a unique opportunity to spend one academic year with faculty and staff of Department of Family and Community Medicine of UND School of Medicine and Health Sciences. The goal of my project was to gain first-hand experience about Family physicians training system in the USA, including both doctoral and postdoctoral programs. During my project period I had a great chance to learn not only about family physicians training system, but also about the whole medical education system in the US. I attended lectures, PCL and lab classes for medical students and residents, visited many hospitals and clinics in North Dakota and always had contacts and discussions with organizers, professors, preceptors and family physicians working in Department of Family and Community Medicine, as well as in hospitals and clinics. To learn about residency programs in Family Medicine I spent a great deal of time in Family Medicine residency centers in Grand Forks and Bismarck. In the beginning of this year, I became an international member of American Academy of Family Physician, it gave me more opportunities to learn about Family Medicine in the United States.

Development of Family Medicine in Turkmenistan is a priority direction in Health Care reform in Turkmenistan under the guidance and leadership of President of Turkmenistan Gurbanguly Berdymuhammedov, who himself is the most experienced organizer of Health Care in Turkmenistan, as he had worked successfully for a long time as Minister of Health Care and Medical Industry of Turkmenistan. At present, Family Medicine is a key link of Primary Health Care and the quantity of physicians makes the main part of all the physicians of the country. Today about 3300 family physicians and more than 5500 family nurse practitioners work in the Primary Health Care System in Turkmenistan. City or Rural Health Houses are the main work places for family practice. Every family physician with one family nurse practitioner serves 1000 population (200-300 families). Family physician is primarily responsible for health care of the assigned population, including prevention, early diagnostics and treatment of diseases. He/she coordinates all health care and, if necessary, can refer patients to other specialists or hospitals. Service, provided by family physicians and family nurse practitioners is absolutely free in Turkmenistan.

Training and retraining of family physicians are provided by Department of Family Medicine of Turkmen State Medical institute and Family Medicine Training Centers. Pre-diploma medical education is 6 years with a different curriculum for Pediatrics and Adult Medicine. Postdoctoral education in family medicine includes 1 year internship and/or 2 years residency (clinical ordinatura) and 1 month courses of continuing education for family physicians (every family physician is required to improve his/her knowledge and skills minimum once every three years).

Comparing American and our medical educational systems, I note some interesting features in American medical education. Introducing them in our medical education system in the future will be very effective for the Health Care System in Turkmenistan:

1. Integrated curriculum for medical students. We don't teach basic theoretical and clinical disciplines contemporarily. Medical education in Turkmenistan is still traditional and we need to integrate it.

2. Clerkship in Family Medicine. There is no rotation in Family Medicine for medical students. We need to introduce a Family Medicine rotation in Medical School as a basic discipline

3. **Good quantity and quality of Family Medicine residency programs**. We began to introduce a 2 year residency program just last year and we need to increase the number of Family Medicine Residency programs.

4. Standardized Board Exams in Family Medicine. We don't have standardized board exams and introducing them will help to improve quality of Primary Care Medicine in our country.

References:

1. Berdimuhammedov G. *Scientific bases of Health Care divelopment in Turkmenistan*. Ashgabat. 2007. (in Turkmen).

2. *National State Programm "Health" by President of Turkmenistan*. Ashgabat. 1995.

3. Seitnepesov K.N., Cushman R. *International experience in Family Medicine. Perspectives for collaboration of Turkmenistan and USA*. // Health Care of Turkmenistan. 2001. ;№2, pp. 2-6. (in Russian).

Continued on page 9

Reprinted by permission from The Teaching Physician Volume 8, Issue 4 October 2009

Information Technology and Teaching in the Office

Advance Directives Online

By Richard P. Usatine, MD, and Craig M. Klugman, PhD, University of Texas Health Science Center at San Antonio

As we teach our students about the major issues in primary care, the benefits of advance directives should not be overlooked. We can role model the importance of an advance directive (AD) by completing our own AD and encouraging and assisting our patients and students to do the same. We have explained to patients that an AD consists of a living will (directive to physician and family) as well as designating a medical power of attorney. We have all handed paper versions to our patients and asked them to complete the form and return a copy to our office, and so few of those forms were ever returned. Also, the time it takes to explain the AD forms may have discouraged you from doing this in all but the most time critical cases (such as a new cancer diagnosis or prior to surgery). Now there are new ways to assist patients, you, your family, and even your students to do their own AD using online forms and online help.

Google has teamed up with Caring Connections to create a system for allowing you and your patients to create a free, state-specific AD and store it online. The Caring Connections Web site (www.caringinfo.org) was created by the National Hospice and Palliative Care Organization with grant support from The Robert Wood Johnson Foundation. In the past 3 years, Caring Connections has distributed more than 2.5 million AD forms (these include medical power of attorney designations). They also provide easy online access to information that helps people understand advance care planning and begin conversations with family and health care professionals.

Google Health is a new password-secured, online Personal Health Record (PHR) that allows users to store, organize, and share important health care information. Google Health links to Caring Connections so users may download a free, state-specific AD and store the scanned documents securely in their PHR. This should help overcome a common barrier in emergency health care situations—finding the AD when it is most needed.

It is relatively easy to store an AD in Google Health and make it available to loved ones and caregivers.

• **Create** a Google Health account at www.google.com/health.

• **Download** and **print** the AD form for your state at www.caringinfo.org/googlehealth.

• Complete the form, **sign** it, and have witnessed or notarized (as your state requires).

• **Scan** the signed document and upload it to your Google Health account. While not every patient may have access to a scanner in their home, there are many public scanners available at a low cost.

• **Share** your profile with loved ones and caregivers so they may have access to this document at the time of need.

It is easy to share your Google Health profile with your doctor, your family, or anyone you like by entering the e-mail address(es) of the person or people with whom you wish to share your profile. An e-mail with sharing instructions will be sent automatically to those persons. Sharing your profile lets others see your profile but not edit it—only you can do that. No one can share your profile with anyone else. You can remove access to your profile for anyone at any time.

These steps will make your healthcare wishes available to those who may need them in a time of crisis. If you or your patient is taken to the ER in an emergency, the AD can be viewed and printed by all those who have access to the Google Health profile. This is why it is so important to share the profile. While the ER doctor is not likely to have access, it is better to have a spouse or family physician with online access than to have a printed copy in the files of the person in their home with no one there to find it. This does not replace the benefit of having an AD scanned into an EMR or having a paper copy filed in a paper chart or hospital record; it merely augments access in a time of immediate need.

We recently downloaded the AD packet for Texas and received a 26 page PDF document with the following components:

• Your Advance Care Planning Packet
• Using these materials
• Summary of the HIPAA Privacy Rule
• Introduction to Texas Advance Directive
• Instructions for Completing Texas Medical Power of Attorney
• Instructions for Completing Texas directive
• Texas Medical Power of Attorney
• Texas Directive to Physicians and Family or Surrogates
• You Have Filled Out Your Advance Directive, Now What?
• Glossary
• Legal and End-of-Life Care Resources Pertaining to Health Care Advance Directives

Fortunately, Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that their advance directives are up to date. Some but not all states have laws authorizing nonhospital do-not-resuscitate orders. Caring Connections does not distribute these forms, so other sources for these forms must be found on a state by state basis.

We have been at the forefront of the online advance directive. In Nevada, Craig Klugman, PhD, helped to create an AD Web site for that state (www.nvlivingwill.com) Teaming together, we were able to create a similar site for Texas (http://

texaslivingwill.org). Texaslivingwill.org is supported by the Center for Medical Humanities and Ethics at University of Texas Health Science Center at San Antonio and was funded by an AT&T grant.

Texaslivingwill.org has a number of features that make it more powerful than Caring Connections for those that live in Texas. The site guides the user to complete the AD online by typing into the spaces provided. In addition to including the Directive to the Physician and the Medical Power of Attorney, this site includes two more documents in English and Spanish that are part of an AD in Texas. These are the Out-of-Hospital "Do Not Resuscitate" Order and a Directive for Mental Health Treatment. Most importantly, it has a full Spanish language mirror site with all the AD forms, directions, and information provided in Spanish.

The Nevada site has much of the same functionality as the Texas Web site and allows for advance care plan-ning in Spanish and Filipino. Nevada allows persons to register their signed living will with a state funded online directory through the Secretary of State's office. If you live in one of the other 48 states, just perform a Google search on "living will" or "advance directive" along with your state's name to see if there is something specific for your location.

Wherever we may live and teach, if we all get on board to increase the use of ADs that are more easily accessible, we can improve care at the end of life for many individuals and families. We have just completed our ADs and scanned them to Google Health. We encourage you to do yours soon so you may advocate for your patients and students to do theirs.

Richard Usatine, MD, University of Texas Health Science Center at San Antonio, Editor
Thomas Agresta, MD, University of Connecticut, Coeditor

Continued from page 7

4.Retraining Course for primary medical care physicians. Partnership Program "Turkmenistan- North Dakota". 2000. (in Russian).
5. Ashgabat, Turkmenistan / North Dakota 1999-2003 http://www.aiha.com/_content/3_What%20We%20Do/Archives/HealthcarePartnerships/AshgabatNorthDakota.asp
6. UND Trains Turkmenistan Health Providers // University Letter. Volume 38, Number 37: May 18, 2001 http://www.und.nodak.edu/dept/our/uletter/may18.pdf
7. U.S. Senator Addresses Opening of Turkmen-American Health Care Center http://turkmenistan.usembassy.gov/pr20010123b.html
8. 6/21/99 -- UND Leading Statewide Effort To Develop Skills-Based Training Program For Primary Care Practitioners In Turkmenistan http://www2.und.edu/our/news/story.php?id=288
9. Strengthening Primary Care in Turkmenistan http://www.aiha.com/en/WhatWeDo/CONNECTIONS/Connections%2006-WINTER2007/Connections%20WINTER2007%20PDFs/CN-WINTER2007-Turkmen%20%20PHC.pdf

2010 Dakota Conference on Rural and Public Health

Registration is now open for the 25th anniversary Dakota Conference on Rural and Public Health to be held April 13-15, 2010, at the Alerus Center in Grand Forks, ND. The conference is an interdisciplinary forum for rural health care professionals, public health professionals, educators, researchers, administrators, and those interested in improving health care services in rural areas.

The theme of this year's conference is "Health Care in Transition: Creative Strategies" and will feature the following keynote presenters

- Jim Hart, MD, Director, Executive Program in Public Health Practice and the North Central Public Health Leadership Institute, University of Minnesota School of Public Health, presenting "Health Leadership for the Emerging Future"
- Robert Kelley, PhD, President, The University of North Dakota, presenting "Innovative Approaches to the Challenges Facing Health Care Delivery in Rural North Dakota"
- Wanda Agnew, PhD, Director of Nutrition Services, Bismarck-Burleigh Public Health; Karen Ehrens, LRD, Health and Nutrition Consultant, Ehrens Consulting; and Sandra Poitra, RD, LD, Community Dietician, Quentin N. Burdick Memorial Health Care Facility, presenting "Food is More than Something to Eat"
Tom Morris, Director, Office of Rural Health Policy, Health Resources and Services Administration, Department of Health and Human Services, presenting a national update on rural and public health in a session titled "Rural Health Care in Transition"

The conference also includes preconference workshops, a variety of breakout sessions, poster presentations, evening workshops, and the annual awards banquet. Go to http://ruralhealth.und.edu/dakotaconference/ for a complete schedule and additional information.

Please register by **noon on Friday, March 19, 2010**, by filling out the online form found at http://ruralhealth.und.edu/dakotaconference/registration.php.

A block of hotel rooms is reserved at the Canad Inns Hotel and Destination Center, which is connected to the Alerus Center. Make your reservation by calling (888) 33-CANAD. To receive a discounted rate of $70 per room, please request the group rate for the Dakota Conference on Rural Health, group reservation 163664. The rooms will be held until Friday, March 19, 2010.

Report from the 2009 Congress of Delegate

Dale Klein, MD

On behalf of our delegation, Heidi Bittner, Jacinta Klindworth, Rich Vetter and myself, I would like to give you an update of our recent Congress of Delegates (COD).

This year's COD was held in Boston. As could be predicted, Healthcare Reform dominated the discussions. Our leadership, Ted Epperly, Jim King, and Lori Heim have made multiple trips to Washington, DC and were invited to the Rose Garden to visit with President Obama. The different provisions in the Healthcare Bills include increase in primary care payment between 5 and 15%. Correcting the inequities between specialty and primary care workforce has also been emphasized.

The patient centered medical home was also much discussed at the COD. Preparing family physicians to capitalize on this reform was discussed. TransforMed, the practice reforming arm of AAFP, is considered the best way to evaluate your practice to see if it is ready to be a patient centered medical home. TransforMed evaluation is free, but if you want to use them to transform your practice there is a fee. Depending on the legislation, you may need to have your practice certified as a medical home to receive the increased reimbursement.

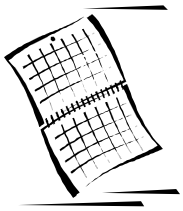
During this time of increased advocacy with healthcare reform underway financial support from family physicians has never been more important. If every family physician gave $100 to FamMedPAC we would have a larger PAC than the trial lawyers. You can access and donate at http://www.aafp.org/online/en/home/policy/fammedpac.html.

Other prominent issues included, withdrawing from the RUC(Relative Value Utilization Co.). The RUC is the arm of CMS that is appointed by the AMA to deal with the value of each procedure or service rendered in medicine. The decision was to continue with RUC while we look for other avenues to increase primary care reimbursement. At present only 4 of over 20 committee members are primary care. Another issue was withdrawing from financial support from Pharma. Oregon introduced a resolution for the AAFP to stop taking money from Pharma. This would have meant about $8 million less to AAFP. Dues would go up $150/yr and the annual meeting would cost about $1200. This resolution was defeated. Many other resolutions were heard including a resolution condemning the murder of George Tiller (the doctor murdered in a church in Kansas).

Candidates elected to the board include Reed Blackwelder from Tennessee, Conrad Flick from North Carolina, and Laura Knobel from Massachusetts. President elect is Rolland Goetz of Texas. Your delegation voted for each of these candidates.

This will be my last COD as a delegate. After 6 years as an alternate and 5 years as a delegate I want to thank you for the privilege of serving in these roles. Your representation at the COD will be in good hands, led by Heidi Bittner. I will continue to serve on the Commission on Finance and Insurance for the AAFP. Thanks much.

PS. I set a new personal record, Lobster 5 times in 4 days.



MARK YOUR CALENDARS!!

January 18-22, 2010
33rd Annual Family Medicine Update
Big Sky, MT

April 13-15, 2010
Dakota Conference **Grand Forks, ND**

July 15-17
NDAFP Annual Meeting **Medora, ND**

September 9-10, 2010
NDMA Annual Meeting **Fargo, ND**

September 16-18, 2010
Advanced Life Support in Obstetrics
Minot, ND

January 17-21, 2011
34th Annual Family Medicine Update
Big Sky, MT

Faculty Position - Family Medicine physician faculty position. We are recruiting for a full-time Faculty member who is ABFM certified or eligible. The chosen applicant will be an Assistant or Associate (depending upon experience) Director in a fully accredited, 15 resident, university administered, community-based family medicine residency program in Minot, North Dakota.

The successful applicant will be expected to participate in clinical care, teaching, and scholarly activity. Competitive salary and benefit package for the right candidate. Send a letter of interest with CV and 3 letters of recommendation to Robert W. Beattie, M.D., Chair, Department of Family & Community Medicine, University of North Dakota School of Medicine and Health Sciences, 501 N. Columbia Road, Stop 9037, Grand Forks, ND 58202-9037 email: beattie@medicine.nodak.edu fax: 701-777-3849 call: 701-777-3200. **UND is an equal opportunity affirmative action employer.**

Program Director – The University of North Dakota Center for Family Medicine-Bismarck is seeking a Program Director to lead a FM residency program with an emphasis on rural family medicine. The applicant must be an ABFM 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 3 letters of recommendation to Robert W. Beattie, MD, Chair, Department of Family & Community Medicine University of North Dakota School of Medicine and Health Sciences, 501 N Columbia Road, P.O. Box 9037, Grand Forks, ND 58202-9037 email: beattie@medicine.nodak.edu fax: 701-777-3849 call:701-777-3200. UND is an EO/AA employer.

North Dakota Academy of Family Physicians - 2009-2010 Officers

Chairman - Steven Glunberg, M.D., Fargo
President - Richard Vetter, M.D., W Fargo
President-Elect - Jacinta Klindworth, M.D., Beulah
Vice President - Wade Talley, M.D., Minot
Sec./Treas. - Jeff Hostetter, M.D., Bismarck
Executive Director - Brandy Jo Frei, Grand Forks

Board of Directors

Todd Schaffer, M.D.	Carrington
Jason Moe, M.D.	Jamestown
Robert Wells, M.D.	Jamestown
Tom Kaspari, M.D.	Beulah
Charles Nyhus, M.D.	Harvey
Hayley Svedjan-Walz, M.D.	Grand Forks
R. J. Moen, M.D.	Bismarck
Heidi Philpot, M.D.	Grand Forks
Derek Wayman, M.D.	Devils Lake

Delegates & Alternates to the AAFP Congress of Delegates

Dale Klein, M.D.	Mandan
Heidi Bittner, M.D.	Devils Lake
Richard Vetter, M.D. (Alternate)	West Fargo
Steven Glunberg, M.D. (Alternate)	Bismarck

Commission Chairs

Fred Mitzel, M.D.	Education
Dale A. Klein, M.D.	External Affairs
Steven Glunberg, M.D.	Internal Affairs
Kim Konzak-Jones, M.D.	Medical Student & Resident

NDAFP Foundation Officers

President - Rup Nagala, M.D., Oakes
Vice President - Kim Konzak-Jones, M.D., Grand Forks
Sec./Treas. - Greg Greek, M.D., Grand Forks

Board of Directors

Kim Krohn, M.D., Minot
Charles Breen, M.D., Hillsboro
Roger Schauer, M.D., Grand Forks
Tracy Martin, M.D., Fargo
Heidi Bittner, M.D., Devils Lake
Russell Emery, M.D., Bismarck

NORTH DAKOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR NORTH DAKOTA

Family Medicine Quarterly

PRESORTED
STANDARD
U.S. POSTAGE
PAID
PERMIT NO. 10
GRAND FORKS, ND
58201

501 N Columbia Rd
Grand Forks, ND 58203

Address Service Requested

The *Family Medicine Quarterly* is published by the North Dakota Academy of Family Physicians and the Department of Family and Community 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 and Community Medicine. The Editors reserve the right to accept or reject any article or advertisement matter.

Address all correspondence and ads as follows: Co-Editors: Roger W. Schauer, M.D. (rschauer@medicine.nodak.edu) and Brandy Jo Frei, (Brandy@ndafp.org) for the NDAFP, *Family Medicine Quarterly,* UNDSMHS, 501 N Columbia Rd Stop 9037, Grand Forks, ND 58203, (701) 777-3200.