NORTH DAKOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR NORTH DAKOTA

Family Medicine Quarterly

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This is the final print version of the *Family Medicine Quarterly*. To ensure that you receive notification of the electronic version, please email Brandy Frei at brandy@ndafp.org with your preferred email address. If you prefer a printed copy, you will need to contact Brandy Frei at NDAFP, 501 N Columbia Rd #2002, Grand Forks, ND 58203 or 701-772-1730.

Issues In This Issue

Roger W. Schauer, MD

Every New Year seems to bring changes, challenges, and opportunities, and 2011 will follow that pattern. Early in January we learned that our **NDMA Executive Director, Bruce Levi**, will be moving on to new challenges. To Bruce I extend my gratitude for his regular and timely submissions to the FMQ as well as his activities to benefit the membership of the NDMA and this NDAFP. Thank you Bruce.

Rob Beattie calls our attention to potential change as he addresses liability issues in his **"The Department of Family and Community Medicine"** column. In her **"Message from the NDAFP President"** Dr. Jacinta Klindworth provides a wonderful comment about change (and maybe a call to action), and goes on to comment about some positive and beneficial changes. Brandy brings us up to date regarding Academy activities in her column.

In **"The 2011 Session"** Mr. Levi informs us about actions already taken by the 2011 Legislative Assembly to monitor the impact of the federal health care activities, as well as a number of bills that will impact implementation of said reform efforts. He also positively notes a lack of apparent effort to undermine our current liability reform (but I refer you back to Dr. Beattie's comments). A number of other bills that will impact your practice are highlighted in Bruce's article, and he notes that updates will posted in the "e-Checkup" provided weekly by the NDMA. Or you can go directly to http://ndmed.org/?id=133 . Contact your legislators to share your concerns.

A few comments about **HB 1353, which would divert the tobacco settlement funds for medical school expansion**. The first committee hearing of HB 1353 is occurring as we go to press, The need to grow our health care workforce is a given, but I am concerned about the diversion of dollars now committed to prevention and cessation of tobacco use. I will share some thoughts about changes in addition to expanding the medical school class size in **"Training, Recruiting, and Retaining Our Health Care**

"Training . . . . . Workforce" While that article is my 'editorial' opinion, I will be happy to provide documentation to support the issues raised.

"Thought Growth", a "guest editorial" from Dean Wynne's office, is reprinted by permission from Randy Eken, MPA, and Associate Dean for Administration and Finance at UNDSMHS. Mr Eken provides a brief (but interesting) history of the growth of our medical school. Randy, who has been with UNDSMHS since 1979 and has worked with five deans during the past 32 years, discusses legislative decisions and support that have been central to that growth of UNDSMHS. You may be receiving E-News regularly if you signed up for it about two years ago, but in the event you are not receiving it, but would like access, the address to the archived files is http://www.med.und.edu/enews/

Best wishes for a great 2011 to all. Please connect with Brandy or me regarding submission of articles, questions, or future issues of the **FMQ.**

The Department of Family and Community Medicine

Robert Beattie, MD

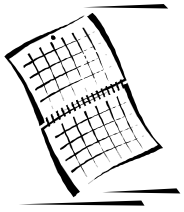
Greetings-
January 1 is an interesting time of year. Often, for us in the north it can be one of the coldest months of the year. It is a time of reflecting on goals and making new resolutions. For us in the business of health care it is also a time for renewal of our medical liability insurance (MLI) policies.

Thinking of malpractice, what happened to tort reform? Where are the doctors, in their white coats, on TV, telling the reporter they will have to leave their state because they can't afford the MLI premiums? Where are the politicians promising to protect patient's access to doctors through tort reform? The past two years has been eerily silent on the topic. Is this a conspiracy of the Obama administration? Is it a political tactic of the right wing republicans? Actually it is neither.
MLI is, in simple terms, a commodity. Like so many things in our economy, such as food, energy or automobiles, the price depends on supply and demand. Insurance price fluctuates based on the demand for it and the available supply.

Many of you will remember the late 80's and the chaos related to the rising cost of liability insurance. Pricing and market factors continued to be issues into the 90's leading to rapidly increased pricing of policies. During the late nineties and into the new millennium, in response to a surge in malpractice law suits and escalating awards, several companies stopped providing liability coverage entirely, such as St. Paul Companies (2001). Some raised rates, like CNA, to discourage purchase of policies and limit their exposure to claims. Others simply went out of business. Most of our practices saw 50 to 100% rate hikes on an annual bases. The realities of the early 2000's drove the call for tort reform. The model, California's Medical Injury Compensation Reform Act (MICRA), passed in a democrat controlled legislature in California in 1975, during a similarly unstable insurance market. MICRA placed a cape on non-economic damages of $250,000, limited attorney fees, strengthened physician discipline systems, disclosed to the jury the presence of collateral sources of payment and called for periodic payments for future damages.

So what has happened to the MLI market?
Insurance is a cyclical market. A "hard" market, like the 90's, is a period of rapidly increasing premiums and tightening supply of policies, often by withdrawal of companies from the market. The hard market is usually in response to skyrocketing judgments (severity) and an overall increasing number of claims (frequency). A "soft" market may be in response to a leveling of claims (frequency) and moderation of jury awards (severity). Overall, this is a simplification of the dynamics at play. There are numerous internal company specifics, such as surplus, that drives the pricing of policies. Suffice it to say; in a soft market, companies can make money, but gamble significant resources that the market won't turn hard.

Most of you have experienced fairly flat or maybe even decreases in your MLI premiums. Enjoy them while they last, because there's one thing certain and that is change. The prediction is the soft market will end sometime in 2011 or early 2012. Tort reform is as important now as it was a couple of years ago. The problem has not gone away. It is merely waiting to present another day. If you have the opportunity, please make your representatives in Washington aware of the issue and what it means to you and the care of your patients.



MARK YOUR CALENDARS!!

March 23-25, 2011
Dakota Conference on Rural and Public Health **Mandan, ND**

April 7-9, 2011
NDAFP Annual Meeting **Minot, ND**

October 29, 2011
Fall CME **Grand Forks, ND**

January 16-20, 2012
35th Annual Family Medicine Update
Big Sky, MT

Message from the NDAFP President

Jacinta Klindworth, MD

This past September, at the AAFP Congress of Delegates in Denver, Colorado, it was very exciting to see Dr. Roland Goertz sworn in as our new President and Dr. Glen Stream chosen as our next President-Elect. It appears the trend of strong leadership at the national level will continue.

During the board of directors speeches, one of the candidates said this about change, "If you don't like change, you'll like irrelevance even less." In my practice, as we transition to our new EHR, I re-read these words a number of times a day as I have since posted them next to my computer. I know I am not alone in my personal frustrations with these necessary advancements in technology. But I am learning to embrace change because in the end, it will allow me to do my job more efficiently and take better care of my patients.

We are also beginning to see changes in our health care environment as a result of the Patient Protection and Affordable Care Act. Dependent children are now able to remain on their parents' insurance until age 26 and there has been an elimination of pre-existing conditions for children. By 2014, pre-existing conditions, that currently exclude adult individuals from health coverage, will be eliminated. Insurance carriers will no longer be able to end your coverage if you get sick with a serious or prolonged illness, and preventative services, such as mammograms for women and immunizations for children must be covered by insurance companies without co-pay or deductible.

This health care reform bill is a step in the right direction although I am hopeful we will see it evolve in to the effective and appropriate legislation this country needs. I encourage you all to stay informed and involved, whether it be at the community, state or national level. Get out there and share your thoughts and insights.

Jacinta Klindworth, MD

Executive Excerpt

Brandy Jo Frei

2011 is here!!! The year has only begun and we are hitting the ground running. As noted on the front of this issue, we are going online. To be sure you receive notification of the new issues available, please email me at brandy@ndafp.org with your preferred email address. Paper copies can be printed upon special request. For these, either email me or call me at 701-772 -1730.

January 16-21 was the 34th Anniversary of the NDAFP Family Medicine Update Conference in Big Sky, MT. What an amazing week! The conference went seamless. We made a few slight changes and they really paid off. The speaker's were outstanding, the food (as always) was amazing, and we received some of the best reviews that we have ever gotten! "Scrambled eggs at breakfast were a great addition." "I have been coming for years and this is the best conference you have ever put together." "This is my first time here and I can't wait to come back next year." Mother nature blessed us a with a few inches of fresh powder mid-week so the skiers were quite happy. I am not a skier, but I did go snowshoeing again this year. The trail is wonderful, family friendly, and truly breathtaking. The Big Sky Resort area has been adding many new features so if you are not a skier, you can find plenty of things to do. Make arrangements now to attend the 35th Anniversary, January 15-20, 2012. I hope to see you there!!!!

We are busy planning many events for this year. The medical students will have an informational panel about the different stages of practice (4th year student, resident, new physician, long time practicing physician) and we will continue with the annual spring dinner before final block exams.

The Annual Meeting is quickly approaching. The dates are April 7-9 in Minot, ND. Make your reservations with the Sleep Inn by calling 1-701-837-3100 and asking for the NDAFP group. Dr. Wade Talley has arranged for a look at the many aspects of diabetes and how to help your patients make the lifestyle changes needed.

The Fall CME continues as a favorite event for the family. The date will be October 29th. The details are still to come as we may try to expand this meeting to include some additional events.

I look forward to seeing you at the many events that are planned.

The 2011 Session

Bruce Levi
Executive Director and General Counsel
ND Medical Association

It is late January and the bill introduction deadlines in the 2011 ND Legislative Assembly have come and gone. From the standpoint of medicine our goals are consistent with previous sessions and many bills are being heard that may impact your practice.

What's new this session is an environment of partisanship over federal health system reform and efforts, in some cases in conjunction with other states, to undermine or nullify that reform, particularly the individual mandate to purchase health insurance. Several bills have also been introduced that would move the state forward, through the office of state insurance commissioner, to implement health system reform (HBs 1125, 1126, 1127). All these bills await committee action. What leaders are saying is that many of the issues relating to the state's implementation efforts including the need for additional staff for Medicaid and the Insurance Department will be addressed later in the special session held for redistricting. The House early on passed HB 1252 which would establish a Legislative Management Health Care Reform Review Committee during the 2011-12 interim to monitor the impact of the federal health system reform, rules adopted by federal agencies, and any amendments to the reform legislation. The bill provides that if a special session of the Legislative Assembly is necessary to adopt legislation in response to the federal legislation, the committee will report to the Legislative Management before a special session; otherwise it will report to the next Legislative Assembly.

What's also new this session is the addition of a second physician in the Legislative Assembly: Spencer Berry, MD, a family medicine physician from Fargo. Dr. Berry serves on the Senate Human Services Committee and provides a good daily perspective on issues for the committee as well as the Senate floor as those issues relate to physician practice.

What we're not seeing are efforts to undermine our state's good medical liability reforms. While last session we were successful in improving our certificate of merit law, no efforts have been made as in the last session to repeal or increase the cap on non-economic damages in medical liability actions. However, in their place are several egregious bills – for example HB 1448 would set up recovery audit contractors as vendors on a bounty system at the state level through the state auditor's office to audit any payments from any state agency, including Medicaid payments. Another effort in HB 1054 sets forth extensive new requirements and protocols for physicians in the provision of pain management to Workforce Safety & Insurance (WSI) patients.

While still early in the session, we've had some success already in defeating two WSI bills. One of the bills, HB 1052, would have allowed WSI to publicly profile physician practices and another, HB 1053, would have set generic prices if cheaper as the standard payment for brand name drugs. In a win for ophthalmologists trying to reduce eye injuries in children, an effort to bring back bottle rocket sales to the state in HB 1255 was also defeated.

A bill originating with residents at the Minot Center for Family Medicine has crossed it first hurdle by passage in the House. This bill, HB 1222, introduced at the request of NDMA and supported by the ND Board of Medical Examiners, would reduce the post graduate residency training requirement for graduates of international medical schools from three years to thirty months for purposes of qualifying for a full and unrestricted medical license. This allows the resident to make timely application to take the ABFM certifying examination in the summer, rather than having to seek an unrestricted license in another state or wait until the fall exam.

I encourage you to spend some time on the NDMA website at www.ndmed.org. As in previous sessions, we have categorized bills and created links to make it easier to find what you're looking for or find out what's going on in the session. You can also sign up directly for the Doctor of the Day program to spend a day at the capitol to roam the halls and watch the action. *We greatly appreciate the Bismarck Center for Family Medicine for covering the Doctor of the Day program each Wednesday.*

This program, so greatly appreciated by legislative leaders and all legislators, has really showcased the importance of primary care physician services, and given the volunteers an inside look at the legislative process. There are still many days in February not yet covered, so please consider participating!

Our NDMA goals are broad in ensuring that medicine is heard during the session. The following summary provides a good flavor for the legislation. Check the NDMA website for more detailed bill summaries and more legislation.

Challenges to physician scope of practice

Nurse Practitioners: NDMA and the ND Board of Medical Examiners opposed SB 2148 which would eliminate the collaborative prescriptive agreement required of advanced practice registered nurses. NDMA testimony focused on the need to continue the use of the collaborative

agreement as a patient safety tool that does not restrict nurse practitioners from their full level of scope of practice.

Lay Midwives: SB 2315 would require the North Dakota Board of Nursing to license any person providing midwifery services under specific requirements and limitations imposed by the legislation; engaging in midwifery without a license would be a class A misdemeanor.

Naturopaths: SB 2271 would create a state "Board of Integrative Health Care" to regulate "naturopathic physicians" and specifies the scope of practice of a naturopathic physician including a naturopathic formulary list.

Pharmacists: SB 2035 would expand the current authority of pharmacists to administer immunizations and vaccinations to children.

Public health initiatives
These are several of the major public health initiatives offered this session:

Trauma System: HB 1226 would put in place a statewide trauma and EMS medical director and state funding for the state trauma system which NDMA assisted in developing with the state's Trauma Committee.

Youth Concussion Management: SB 2281 would require that any student or youth athletic activity that is sponsored or sanctioned by a school district or other political subdivision be subject to the terms of a concussion management program.

Tobacco: HB 1025 would appropriate $12,882,000 to the Comprehensive Tobacco Control Advisory Committee for the biennium.

Universal Vaccine Program: SB 2276 would establish within the Department of Health a vaccine group purchasing program.

Driving: HB 1256 would incorporate graduated drivers licensing concepts for young drivers in North Dakota's motor vehicle licensing law. HB 1195 would prohibit the operator of a motor vehicle that is part of traffic to use a wireless communications device to compose, read, or send an electronic message.

Expanded coverage for uninsured and underinsured people, including children
Healthy Steps: SB 2264 would change the eligibility test for Healthy Steps from a net income eligibility limit of 160% of the poverty line to 200% of the poverty line. Two other bills would move the limit to 250%.

Medicaid payment increases
Last session, NDMA was successful in rebasing physician Medicaid payment *through $40 million in additional state/federal funding to rebase physician payments to 89% of cost, resulting in a substantial increase. This session's executive budget in SB 2012 maintains that level of reimbursement with proposed 3% increases in each year of the upcoming biennium. NDMA testimony encouraged lawmakers to further rebase physician payments.*

UNDSMHS budget and strategies to meet future health care needs
UNDSMHS Budget: HB 1003 would provide base level funding of $40,890,401 and additional enhancements of $5,763,005 for the UNDSMHS. The budget provides an increase of $2.1 million for parity, which includes a 3 percent annual salary increase, actual health insurance premium increases, and inflationary adjustments for building utilities; allocates $591,552 from the $10 million equity pool; and recommends $571,224 to limit annual tuition rate increases to 2.5 percent for the biennium. The bill also appropriates $2.4 million for the joint UND/ NDSU Master's in Public Health program and expanded geriatrics training program.

UNDSMHS Expansion – Tobacco Funding Redirection: HB 1353 bill would change the statutory purpose of the UND School of Medicine & Health Sciences to "increase the health care workforce in the state by educating physicians, with a focus on the education of primary care physicians, and other health professionals and to enhance the quality of life in North Dakota." The bill would also change the composition of the UNDSMHS Advisory Committee to require most of sixteen members to be appointed by the Governor. The bill would appropriate $28,900,000 from the tobacco settlement funds to construct a new health sciences facility at UND and appropriate an additional $5,800,000 from tobacco settlement funds for the purpose of increasing the number of medical and health sciences students at the UNDSMHS and the number of residency training positions in the state.

While NDMA supports UNDSMHS expansion, NDMA opposes provisions in the legislation that would divert tobacco settlement dollars. The bill would transfer tobacco settlement dollars obtained by the 1998 court agreement currently used as the Tobacco Prevention and Control Trust Fund to fund the state's comprehensive tobacco and prevention and control plan to the UNDSMHS and programs related to increasing the health care workforce in the state, with a focus on the education

of primary care physicians It would repeal the statutory tobacco prevention and control program created by 2008 Ballot Measure 3.

Medical practice including strategies and plans for health information technology

Health Information Exchange: SB 2037 would provide a statutory structure for health information exchange in North Dakota. Effective January 1, 2015, an executive branch state agency, an institution of higher education, and any health care provider or other person participating in the health information exchange would be required to use only an electronic health record system for use in the exchange which is certified under rules adopted by the federal Office of the National Coordinator for Health Information Technology.

Electronic Prescription Standards: HB 1422 would set standards to apply to all electronic prescribing devices used within this state and to all software and hardware vendors and content managers with respect to electronic prescribing devices. SB 2122 would revise the state's prescription laws relating to brand name drugs to incorporate electronic prescriptions.

Medical Records Copying: HB 1174 would change the current statutory basis for medical record copying costs.

NDMA is also monitoring and taking action as necessary on other legislation. Check the NDMA website and watch for e-Checkup emails every week during the session. As always, these are interesting times. At the state level, NDAFP and NDMA provide the best means to act as one voice in helping to shape your future practice environment.

The story behind the transition to creating an electronic FMQ

Roger W. Schauer, MD

During the 2010 Annual Meeting of the NDAFP the Academy Board of Directors voted to discontinue distributing hard copy of the FMQ, unless specifically requested by members. We fully intend to continue publication, but the FMQ will hence-forth be on-line. You will receive an e-mail notice from Brandy whenever new documents are posted. Brandy will need to know your preferred e-mail address for receiving these notices. The FMQ is available at http://www.ndafp.org/family_medicine_quarterly.php

Currently the UNDSMHS web pages are being revised. Once those revisions are in place we can begin making changes on the **FMQ website** to enable search capabilities and quicker links to the minutes of the various commissions and the Academy boards as well as articles pertinent to teaching and learning. In the past we have simply filed the FMQ by total document. I hope to make changes that will allow direct linkages to the minute of each of the various commissions and board of directors for both the Academy and the NDAFP Foundation. Separate links could be created for faculty development articles, for residency selection reports, for conference reports, to alert you to future conference, or whatever the membership would deem helpful.

We welcome your comments and suggestions.

Training, Recruiting, and Retaining Our Health Care Workforce: Can we do better in North Dakota?

Roger W. Schauer, MD

North Dakota colleges and universities have long prepared a substantial portion of our state-wide health care workforce, in addition to educating providers that serve the rest of the nation and the world. But we face important issues related to distribution and retention our own state workforce, especially in rural and more remote communities. Training ***more*** may only be a small component of the solution. How we get them to rural and remote and keep them there may require alternative approaches to our traditional training programs.

This past October (2010) I had the opportunity to travel across much of eastern Australia to attend scientific session addressing medical education and education for medical school faculty. Some of the time was spent visiting with physicians in a number of very rural and remote ("outback") communities. We found physicians in practice in these communities to be enthusiastically engaged in teaching both medical students and residents, but also providing learning opportunities for other health care professionals.

Distributive and community engaged education
A number of Australian medical schools have adopted and adapted to **distributive and community engaged medical education** in rural and remote settings, with some of those placements occurring as early as the 1st and 2nd years of medical school. A number of those programs have students return to the same community up to five or six times during their medical school training. Other schools have established **longitudinal, integrated continuity experiences**, comparable to the Minnesota Rural Physician Associates Program (**RPAP**) and our own Rural Opportunities in Medical Education (**ROME**). Those rural placements are generally for an entire year, rather than the nine month experience for RPAP and our own more limited 28 weeks experience for ROME. Outcome studies for the various programs document that the educational experiences, including standard multiple choice examinations, reveal that examination scores are equal to or better than those for students in traditional urban teaching hospitals. Plus, those students return to those communities or other rural and remote settings to establish practices at a much higher rate than their urban counterparts.

Vertical integration in Australia
Visiting physicians in their communities provided opportunities to meet with General Practice Registrars (read – 'Family Medicine Residents') who were completing residency requirements during rural placement of variable lengths of time, from 2-3 months to a year. In addition to the Registrars these same physicians also hosted and mentored medical students at various stages of their education. A number of these students received their early clinical experiences (much like our **Don Breen** and **SEARCH Externships**) and returned to the same communities for more advanced medical student and residency experiences. And we met a number of physicians, now in practice in those communities, who had completed a substantial part of their medical education or Registrar training in those communities.

Vertical integration in the USA
The WWAMI program out of the University of Washington School of Medicine may be the best example the USA has for addressing medical education and physician supply. WWAMI has been pursuing their distributed program for over 35 years, and covers five states including Wyoming, Alaska, Montana, Idaho, and Washington. In addition to distributive, it is vertical because elements of the program begin in K-12 and continue through college, medical school and residency. And their outcomes are similar to those in Australia, in that over 60% of WWAMI graduates establish practices in one of the five program states, over 50% pursue primary care, and over 20% practice in Health Professional Shortage Areas (HPSAs).

In WWAMI workforce pipeline efforts begin early, including dedicated opportunities for high school students to work in research labs, in medical and dental education programs, and in medical underserved areas during the summer. Many of the students engaged in those summer activities pursue careers in medicine or related fields. Once in medical school those students have further opportunities to receive training in rural and underserved areas. A number of other medical schools in this country have developed programs that identify students from rural and underserved areas as early as high school, then support those students through college with guaranteed seats into medical school. Because many of those programs are newer the outcomes are yet to be determined, but the trends suggest that a higher percentage return to work in their rural and underserved communities.

While training more physicians may ultimately result in increased physician supply in rural and underserved areas, we need to consider alternative methods to supply the teaching.

Thoughtful Growth

Randy S. Eken, MPA
Associate Dean for Administration and Finance
UND School of Medicine and Health Sciences

(reprinted by permission from E-News, Friday, January 28, 2011 http://www.med.und.edu/enews/archives.cfm

Over-the-hill, long-in-the tooth (I prefer seasoned), whatever your term might be, I have worked for the School of Medicine & Health Sciences (SMHS) for a long time. I started with the SMHS in June 1979 and have been directing the administrative and financial affairs of the SMHS since November 1983 (Dean Joshua Wynne is my fifth boss/dean!). Currently, there is extensive debate in the 2011 N.D. Legislature (and media) about the SMHS's Healthcare Workforce Initiative. This initiative, if funded, would result in the most extensive expansion of the SMHS since the 1970s. Over the course of my years at the SMHS, I have developed some perspective on the historical role the N.D. Legislature and the State Board of Higher Education (SBHE) have played in the growth and maturation of the SMHS. I want to share a little of my perspective with you in this column.

The School of Medicine and Health Sciences came into existence, as a two-year Bachelor of Science in Medicine program in 1905 (talk about vision from state leadership!). Since its inception, the SMHS has been subject to many studies and examinations by the Legislature, SBHE, and our accrediting bodies. In the 1980s, Dean Tom Johnson referred to these seemingly endless examinations as "paralysis by analysis." Really though, we should be flattered by the attention. These examinations are demonstrations that North Dakotans really do care about the outcomes of our work at the SMHS. What are the common questions that direct state leaders to examine our "little SMHS on the prairie"? You must surely always start with the simple fact that we are the least populated, most rural state with its own medical school. As a humble, modest people, we North Dakotans have typically underappreciated both our medical resources and expertise, feared runaway costs and questioned whether the outcomes produced by the SMHS would justify the costs.

In the early 1970s, the SMHS's accreditation agency determined that they would no longer accredit two-year (B.S.) medical schools. A crisis ensued, and in 1972 the State Board of Higher Education directed a study (by Booz-Allen & Hamilton) focused on the future of the SMHS in North Dakota. Would we start a full four-year medical school program, contract with other states' medical schools (Minnesota came to mind) to educate our students, or would we simply discontinue the SMHS?

After extensive study and legislative debate, the conclusion was that it was vital that North Dakota immediately begin the process of developing a full four-year medical school, with appropriate residency programs. The health care workforce needs of North Dakota needed to be provided, to a large degree, by N.D.-trained health care professionals. The study also concluded that the cost–benefit ratio also favored having a full four-year medical school in North Dakota. The 1973 Legislature concurred with these recommendations and the SMHS began implementing the plan. Importantly, extensive federal funds, including federal capitation grants, a seven-year Veterans Administration grant (which included a new building in Fargo), and a multiyear federal Area Health Education Center grant, allowed the state to gradually transition additional state general fund costs for the SMHS's expansion over a period of four biennia.

In 1986, just a few years after the federal transition funds for the new four-year SMHS were exhausted, the SBHE and N.D. Legislature became very concerned about the costs of the SMHS and commissioned another study. The study (by Ernst & Whinney) focused on questions of the full costs of the four-year program and program outcomes. The conclusion was that the economic benefits of the SMHS strongly outweighed the funding costs. The study determined that redistribution of resources within the SMHS was required and full implementation of the SMHS was necessary. The study recommended a restructuring of the SMHS, including closing the Fargo Family Medicine Residency program (the first time) and admitting WICHE students into the SMHS (WICHE, the Western Interstate Commission for Higher Education, comprises "15 member states that work to improve access to higher education and ensure student success": http://wiche.edu/). The 1987 N.D. Legislature concurred with the recommendations, and the SMHS implemented the plan.

In 2007, the N.D. Legislature directed the State Auditor's Office to conduct a performance audit of the SMHS. This audit came as a result of the Legislature's concerns about the fundamental mission and operations of the SMHS. The audit resulted in many recommendations to refocus our mission and improve our operations. The 2009 N.D. Legislature was presented the audit and accepted the audit findings. The SMHS's swift implementation of the audit recommendations (our follow-up audit was completed in November

2010) may have given confidence to state leaders that the SMHS is well prepared for further challenges.

Sometime in the mid-1980s, as we were struggling with the "paralysis by analysis" period of the SMHS, the late Dr. Richard Stadter, then chair of the Department of Neuroscience gave me some very good insight on what the SMHS might look forward to over the next couple of decades. Dr. Stadter had studied organizational development, and he observed that most new state agencies, or major expansions of state agencies (like North Dakota's new four-year medical school), take at least 20 to 30 years to become part of the infrastructure of the state's political and social culture. During that long maturation process, there would be periodic doubt about the real viability and survival of the state agency. In retrospect, I believe Dr. Stadter was correct in his insight and that this has proven true for our SMHS in North Dakota. I also believe that we have now moved past this development stage.

In the fall of 2008, the SMHS and its Advisory Council began working on the Healthcare Workforce Initiative that is currently being debated. This initiative did not result from directives given by either the SBHE or the N.D. Legislature. Instead, the initiative came from SMHS's analysis of heath care workforce needs in North Dakota and what the SMHS might do in response. Perhaps the Healthcare Workforce Initiative is evidence of further maturation of the SMHS through its being proactive, accountable, and responsible to the citizens of North Dakota.

This week, Dean Joshua Wynne, Dave Molmen and other SMHS leaders presented the Healthcare Workforce Initiative to the 2011 N.D. House Appropriations Committee and had further discussions about the Initiative with the SMHS Advisory Council. It is remarkable to me that no longer is there even a question about "should we have a SMHS in North Dakota?" Instead, the questions surrounding the SMHS today revolve around finding the right mixture of programs and funding (yes, we shall still debate costs) to serve the health care needs of North Dakota.

I have complete faith that the 2011 N.D. Legislature will provide (as they always have) the SMHS with appropriate guidance and budget, which will enable the SMHS to provide for the current and future health care needs of the citizens of North Dakota.

CALL FOR NOMINATIONS

Brandy Jo Frei

It is time to submit your nominations for the following awards:

Family Physician of the Year

The award is given once a year to a physician in North Dakota who shows pride in practicing family medicine.

The criteria include:

1) being a member of the NDAFP and AAFP;
2) a compassionate family physician;
3) in good standing in the medical community;
4) involved in community activities,
5) dedicated to the ideals of Family Medicine;
6) a role model for the residents, medical students, and young physicians in the state..

Friend of Family Medicine Award

The award is given annually to recognize an individual's contributions to our specialty or our academy.

The recipient of this award is an individual who has achieved one or more of the following criteria:

1. Worked diligently for the NDAFP to further the ideals of family medicine
2. Made a significant contribution to the NDAFP, its members and their patients
3. Been an outstanding teacher of family medicine in either academic or a clinic setting
4. NDAFP Members as well as non-members and non-physicians are eligible for this award

To submit a nomination, please email Brandy at Brandy@ndafp.org of call 701-772-1730.

2011 Annual Dakota Conference on Rural and Public Health - New Horizons in Health Care

March 23-25, 2011 - Seven Seas, Mandan, ND

Who Should Attend

- Rural health care professionals
- Public health professionals
- Mental health professionals
- Researchers
- Social workers
- Administrators—nursing home, hospital and clinic
- Nurses
- Dietitians
- Educators
- All individuals interested in improving health care service in rural areas

Objectives

1. Provide continuing education to health and human service administrators, managers, researchers, and clinical providers in the areas of
   - health care administration,
   - health promotion and disease prevention,
   - environmental health and occupational health, and
   - diverse populations and health disparities.
2. Create an environment of learning that is informative and educational to an interdisciplinary and multidisciplinary audience of health and human service professionals.
3. Provide conference participants with the opportunity to formally present community-based solutions to common rural and public health issues.
4. Provide conference participants with the opportunity to informally network with others to share skills and strategies meant to address access, financial, and quality-of-care issues found in rural and public health.
5. Foster an environment that is conducive to collaboration between different organizations, health and human service disciplines, and communities.

The Dakota Conference is Facilitated by

Center for Rural Health, The University of North Dakota (UND) School of Medicine and Health Sciences (SMHS)

Supporting Partners

- Altru Health System
- Center for Rural Health (UNDSMHS)
- College of Nursing (UND)
- Department of Family and Community Medicine (UNDSMHS)
- North Dakota Public Health Association
- North Dakota Rural Health Association

Keynote Presentations

- Linda Rae Murray, MD, MPH, President, American Public Health Association - *"Health Care Reform and the Impact on Public Health"*
- Dennis Berens, Immediate Past President, National Rural Health Association; Director, Nebraska State Office of Rural Health– *"Community Matters"*
- Kostas Voutsas, MBA MSHR/OD, Assistant Professor of Business, Dickinson State University - *"Secrets to Making Diversity Work"*
- TBD- *Health Information Technology*

Topics

- Millennial generation
- Tobacco cessation
- Quality of life for people with dementia
- Suicide prevention
- Public health accreditation
- Refugee health
- Building healthy communities
- Workforce
- Nutrition
- PTSD
- Health information technology
- Social networking
- Community based participatory research
- Human trafficking/exploited/missing children in rural America
- Education opportunities in North Dakota
- Intimate partner and sexual violence
- Diabetes care interventions
- Best practices in patient care
- EMS

Format

Dakota Conference includes preconference workshops, keynote speakers, a variety of breakout sessions, poster presentations, evening meetings, and the annual awards banquet.

Go to http://ruralhealth.und.edu/dakotaconference for a complete agenda.

Two Ways to Register

- **Online**—Register online and request an invoice at ruralhealth.und.edu/dakotaconference.
- **Mail**—A printable registration form is available at the link above. Please complete the form and return it with your payment by February 25, 2011. Payment must be received by the CRH on or before February 25, 2011 to be eligible for the early bird discount.

Hotel Reservations

Make your reservation now! Dakota Conference has a block of rooms reserved at the Seven Seas Hotel and Waterpark. The state rate is accepted at this hotel. The rooms will be held until March 8, 2011. Please request the Dakota Conference room block. To make your reservation, contact 701-663-7401 or 1-800-597-SEAS. Their website is http://book.bestwestern.com/bestwestern/productInfo.do?propertyCode=35014. *The Seven Seas is a smoke-free facility.*

Cancellations and Substitutions

All registrations are non-refundable. Substitution may be accommodated. Please make changes by March 11, 2011.

Questions?

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UND School of Medicine and Health Sciences
701-777-5380
kylie.nissen@med.und.edu or visit: ruralhealth.und.edu/dakotaconference/

NORTH DAKOTA ACADEMY OF
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