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THE CURE FOR THE COMMON CLINIC

“A fabulous design process led to an innovative clinic that will have a direct impact on our patients.”

Jeff Hoss, Vice President of Clinical Operations, Sanford Health Fargo

SANFORD MOORHEAD CLINIC | MOORHEAD, MINNESOTA

JLG DESIGN FOR LIFE

Inc. Magazine’s 50 Best Places to Work in America | Architect Magazine Top 50 US Firm
Welcome to Insight

As I write this, we are halfway through the 2017 Legislative Session. Insight is about looking into the future and, in order to move forward, I would like to provide a little information about the recent past.

In Washington, we have a new President and Congress is controlled by the same party as the White House.

In North Dakota, the 2017 Legislative Session started with a new Governor. Governor Burgum comes not from the political environment but from the information technology world. Also new to the legislature are ten new Senators and twenty-five new Representatives. With all the new people, there is a learning curve that has to be mastered. Education is an ongoing process not only with how the process works but with all the information that comes with each session. Legislators are being asked to make decisions on: agriculture, health care, transportation, water, education, taxes, and the list goes on.

The importance of understanding this process is we either succeed or perish by the decisions that are made here in Bismarck and in Washington, D.C. Everyone needs to be part of the process by sharing data.

Two issues that will have a dramatic influence on our future are: the repeal and replacement of the Affordable Care Act (ACA) at the federal level and the loss of revenue due to low oil and agriculture prices.

Medicaid expansion as part of the ACA has been an asset to approximately 20,000 people in North Dakota. These 20,000 people now have a health care plan and access to a primary care physician. Chronic issues as well as everyday issues can now be taken care of in a clinic setting instead of the emergency room. If the ACA model is changed to reduce or eliminate insurance coverage for these people, it will be a step backwards.

In regards to the downturn in oil prices and agriculture prices, all of North Dakota is being affected. Services are being evaluated at the state, county, and city levels to determine if they need to be scaled back or even eliminated.

The next few months will have a long-lasting effect on the state’s economy and the delivery of health care.

Jerry Jurena, President
ND Hospital Association
Every 40 seconds, someone in the United States dies of heart disease – about 2,150 deaths each day. In North Dakota, more than 1,600 people die of heart disease and stroke each year. However, 80 percent of those deaths could be prevented.

One of the keys to preventing death and disability from heart disease and stroke is timely response to critical medical emergencies, such as sudden cardiac arrest, heart attack and stroke. However, in rural North Dakota, there can be time delays before first responders can arrive at the scene in time to help patients.

The typical “Chain of Survival” for cardiac and stroke emergencies starts with the immediate recognition of cardiac arrest, activation of the emergency response system, early CPR and rapid defibrillation. These initial steps in the chain depend significantly on the presence of trained bystanders – individuals who can identify and react appropriately to a sudden cardiac emergency.

In an effort to strengthen these first important links in the Chain of Survival, the North Dakota Division of Emergency Medical Systems has partnered with the American Heart Association to develop and implement...
the Cardiac Ready Communities program, which aims to help communities prepare to respond and assist if an individual has a cardiac event.

“Seconds matter when a neighbor, co-worker or family member has a cardiac event, and in rural North Dakota, there can be time delays before first responders can arrive on the scene,” said Jeff Sather, M.D., North Dakota State Medical Director. “No one should lose a loved one because no one nearby knew how to help. Communities working together to create a chain of survival can make all the difference in whether a person survives a heart-related emergency and with less heart damage.”

The Cardiac Ready Communities project was first launched through a pilot initiative in Powers Lake in 2015. Powers Lake Ambulance Crew Members Jake Douts and Kari Enget served as community co-chairs for the effort.

“All of these small towns in rural North Dakota need to have bystander CPR and AEDs available,” said Douts. “Our goal is to ensure that in our community, if anyone has a cardiac emergency, there will be someone close by to help and take care of them.”

The Powers Lake project included several elements designed to improve the town’s ability to respond to cardiac emergencies. The project steering committee included a cross-section of the community, including worksites, faith-based organizations, city leadership, farmers, fire and EMS. Through a series of community events and activities throughout the initial months of the project, Powers Lake was able to train more than 200 individuals in CPR and placed 24 AEDs throughout the community.

With the initial success of the Powers Lake project, the North Dakota Department of Health opened the program to additional communities, and to date, 13 groups covering 16 North Dakota communities have filed letters of intent to become Cardiac Ready Communities.

To become Cardiac Ready Communities, a community must achieve a set of minimum criteria, which support the chain of survival, including CPR instruction, public access to AEDs, hypertension screenings, and resuscitation protocols and transport plans for first responders and area hospitals.

"We need leadership, and depending on the community, they can set that up how they want to. If they have medical people such as hospital or ambulance service, certainly they are key players," said Dr. Sather. "Also, Chamber of Commerce, church groups, civic organizations, all of that can be involved in that leadership in the community.”

During the 2017 North Dakota Legislature, House Bill 1210 was passed and created a Cardiac Ready Communities grant program within the state Department of Health. The purpose of the grant program was to enable the State Department of Health to secure funding for the Cardiac Ready Communities program from outside sources and distribute funds to communities seeking assistance with implementing aspects of the Cardiac Ready Communities project in their community. The grant program also allows for the Department of Health to initiate a bid process to reduce the cost of AEDs for communities who are working towards Cardiac Ready Community designation.

Dr. Sather believes that the Cardiac Ready Communities project is a great way to continue the progress already made in recognizing and treating heart disease.

"I expect, even in our rural states - in North Dakota - we will see within a few years heart disease may not be the #1 killer anymore because we are making such great strides in reducing deaths from cardiac disease,” he said.

For more information on the Cardiac Ready Communities project, visit the North Dakota Department of Health’s Division of EMS & Trauma website at www.health.nd.gov.
EMERGENCY PREPAREDNESS

EMS RULES

By: Ruth Hursman, ND Dept. of Health, Emergency Preparedness, Response Section

More regulations and new rules to comply with are never something that the health care industry wants to hear. There is often a feeling that the industry is already over regulated and that it is overwhelming to keep up with the never ending changes. Last fall, the Centers for Medicare and Medicaid Services (CMS) put new emergency preparedness regulations into place in an attempt to establish a national standard of preparedness that would be consistent across numerous health care provider types. These rules require facilities and health care providers to meet certain planning, training and communication standards. The implementation date for these new rules is November 15, 2017. This means that the rules are in effect now, but that there is recognition that it takes time to come into compliance. Thus, the survey teams will not be expecting everything to be in place to meet these rules until November of this year. This leaves approximately six months for facilities and providers to complete the necessary assessments, planning, exercising and training to meet these standards.

Devastating events, such as 9/11, Hurricane Katrina, tornados across the Midwest and infectious diseases such as H1N1, have led to an acute awareness of the diversity of disasters. Disasters, both natural and man-made, can seriously impact the health care system. These events impact facilities and providers of all types. They put the safety of people across the nation at risk. Preparing, before a disaster occurs, is essential in ensuring that employers and workers have the necessary equipment, skills and knowledge to keep the population safe when an emergency occurs.

Past disasters have helped to identify gaps within the current the health care systems’ preparedness level and its ability to respond. It is recognized that not all health care providers had the necessary emergency planning and preparedness in place to adequately protect the health and safety of the patients they serve. Responses often lack coordination. The federal government was initially unsure of the best approach to ensuring these gaps were adequately addressed. Should preparedness be incentivized? Should rules be created to mandate preparedness? The decision was made to address these gaps with standards that ensure a consistent level of preparedness across the health care continuum. Preparation, planning and a comprehensive approach to a disaster is essential.

It is recognized that that people with medical needs are cared for by many different facilities and provider types. Each of these providers needs to be prepared to meet their population’s needs at the time of a disaster. The CMS final rule affects seventeen different provider types (both inpatient and outpatient) who currently receive Medicare and Medicaid reimbursement. These provider types include hospitals, critical access hospitals, Religious Nonmedical Health Care Institutions, Psychiatric Residential Treatment Facilities, Long-Term Care Skilled Nursing Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities, Ambulatory Surgical Centers, Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services, Community Mental Health Centers, Comprehensive Outpatient Rehabilitation Facilities, End-Stage Renal Disease Facilities, Rural Health Clinics and Federally Qualified Health Centers, Home Health Agencies, Hospice, Organ Procurement Organizations, Programs of All-Inclusive Care for the Elderly, and Transplant Centers. These new rules do not impact assisted living facilities or providers that do not receive reimbursement from CMS.

The emergency preparedness rules are made up of four components. These components are consistent with the National Preparedness Cycle. They include emergency planning, policies and procedures, communication planning and training and testing. There are additional requirements for some facility types to ensure the continuity of operations with emergency and standby power sources.

Emergency Plans: An emergency operations plan must be created that is based upon a hazards vulnerability assessment or all-hazards risk assessment. This assessment should include various natural and man-made events that could potentially impact the facility’s ability to provide care. In addition to identifying the risks that an organization faces, the assessment should consider the capabilities that the provider has in place to mitigate those risks. This includes facility resources as well as local, regional and state resources. After completion of the assessment, the emergency operations plan is developed based upon the information gathered in the assessment. The emergency operations plan must address the special needs of the population that the organization serves and must be reviewed and updated annually.

Policies and Procedures: The provider or facility must develop and implement policies and procedures based upon the all-hazards risk assessment and the emergency operations plan. These policies and procedures should
address evacuation, sheltering in place, tracking patients and staff, medical documentation and staff and patients’ needs such as food, water, medical and pharmaceutical supplies. Alternate energy sources to maintain climate control, emergency lighting, fire detection and extinguishing, and sewage and waste disposal should be considered. Like the risk assessment and emergency operation plans, the policies and procedures must be reviewed annually and updated as needed.

**Communication Plan:** Emergency communication plans are required for facilities and providers. These plans must comply with federal and state laws. They must ensure the ability to effectively communicate during a disaster with other health care providers, emergency managers, and state and local health departments. Primary and alternate communications modes must be identified and contact lists maintained for people and services such as patients, family members, employees, and providers of essential services. Information sharing and release of patient information are also components of the plan that should be included.

**Training and testing Program:** Protocols must be developed to address how employees will be trained on the emergency operations and communication plans. Training must be completed initially upon hire and annually thereafter to ensure an understanding and ability to respond during a disaster or event. This training must adequately teach emergency preparedness concepts included in the plans, policies and procedures. Documentation of this training must be maintained. The training must be taken a step further to include conducting drills and exercises to test the emergency plans. This includes a minimum of two exercises annually. One exercise must be a community-wide full-scale exercise or real-world event. This means partnering with other organizations or resources within the community to test various aspects of the plans. The second exercise can be a tabletop exercise. This exercise does not necessarily require the involvement of the community.

**Emergency and Standby Power:** Hospitals, critical access hospitals and long-term care facilities are required to have access to generators and to conduct generator inspection, maintenance and testing. These facilities must maintain sufficient fuel to sustain power during an emergency. Home health and Hospice agencies are not required to maintain generators, but must be prepared to share information with officials regarding the patients that they care for who may be in need of evacuation.

These new requirements may seem daunting and overwhelming. They will force many facilities and providers to go beyond the preparedness planning that they have done in the past. Organizations who have not previously engaged in community preparedness will need to do so. The new emergency preparedness rules will definitely go a long way to enhancing the overall preparedness of the health care community.

For inquiries, call or email Kevin: 701-214-4228 | kevinl@bektel.coop
In 2014, the Veterans Access, Choice, and Accountability Act (“Choice Act”) was signed into law in large part to improve Veterans’ access to care from non-VA providers.

As directed by the Choice Act, the Veterans Choice Program allows for Veterans enrolled in VA health care to receive care within their community instead of waiting for a VA appointment or traveling to a VA facility. Veterans are eligible for the Veterans Choice Program if any of the following apply: they have been (or will be) waiting more than 30 days for VA medical care, or they live more than 40 miles away from a VA medical care facility or face one of several excessive travel burdens.

While the Veterans Choice Program has been successful in some locations across the country, many locations exhibited unique challenges for the program’s third-party administrators (TPAs), HealthNet and TriWest. Veterans in North Dakota and western Minnesota geography are served by HealthNet, and Veterans repeatedly reported concerns that their calls and interactions to schedule their community medical care resulted in coordination challenges, partially attributed to HealthNet’s lack of understanding of the area’s geography.

In response to these concerns, in October 2016, Veterans enrolled in the Fargo VA Health Care System who are eligible for the Choice program began to work directly with VA staff located in Fargo to help schedule and coordinate community medical care appointments.

Entitled the Choice Program Care Coordination initiative, Veterans can contact the Fargo VA Health Care System Clinical Resource Management Department at 866-517-9363, to facilitate their healthcare needs in their respective communities.

Because of an understanding of the local geography and relationships with community providers, Fargo VA staff help Veterans schedule and coordinate community care appointments. HealthNet will continue to provide administrative and provider support.

“The Department of Veterans Affairs is working every day to improve the community care experience,” said Dr. Baligh Yehia, Assistant Deputy Undersecretary for Health for Community Care. “Innovative solutions like this one, developed in direct response to Veterans’ and community providers’ concerns, are key to the development of our consolidated community care program. We cannot lose sight that healthcare is local and we will need flexibility to meet the needs of each community across North Dakota, Minnesota, and the nation.”

The Fargo VA’s Choice Program Care Coordination initiative is one of only a few of its kind in the nation. This initiative is one of many ways VA is working to improve the community care experience for Veterans. VA is also actively working with all its partners, especially Congress, to simplify community care eligibility criteria, streamline clinical and business processes, and standardize provider payment. The VA is committed to providing a Community Care program that is easier to understand, simple to administer, and improves the community care experience for Veterans, providers and VA Staff.

“I am very pleased to see the focus placed on local Veteran and provider needs,” said Lavonne Liversage, Fargo VA Health Care System Director. “Having Fargo VA staff work directly with Veterans and our community healthcare providers allows for better communication of care needs and improved Veteran experience; this initiative benefits those who have given so much.”

For more information or questions relating to the Care Coordination initiative, contact the Fargo VA Health Care System Clinical Resource Management Department at 866-517-9363.
For the past 22 years I have had the privilege of working for Quality Health Associates of North Dakota (formerly North Dakota Health Care Review). Our mission is to improve health and healthcare for the people of North Dakota. With that mission as our guide, we are focused on being an objective, trusted, and helpful resource to all of you doing the challenging and important work of meeting the healthcare needs of our population. Our work has allowed me to observe and understand healthcare quality in our state from multiple perspectives. As I near my retirement date of May 1, I hope you will indulge me the opportunity to share just a few personal reflections about quality and healthcare in our state.

Recently, as I was out running my usual rounds of Saturday morning errands, I ran into a longtime friend of mine who also happens to be a healthcare provider. We talked about what was going on in our lives… travel, family, health, politics of course, and finally… our jobs. As friends “of a certain age” I mentioned that I was retiring from QHA in the spring, and asked what her plans were. The conversation turned to how much my friend likes taking care of patients, but how it seems like more and more time is devoted to everything but patient care, and how frustrating that is for her. I didn’t take the time to ask her what those “everything but” things were. I was in a hurry to get on to the next errand. But if I am being totally honest, I also didn’t ask because at that moment I was afraid of what her answer would be. What if if turned out that the “everything but” was something we at QHA were asking providers to do? What if “everything but” was one of our activities or quality improvement initiatives or priorities, and I would be faced with the perception that not only was what we do not valued, but that it in fact was getting in the way of good care?

I have been thinking about that conversation a lot ever since. I knew what she meant. Taking care of patients, the face to face encounter whether in a clinic, or an ER, at a hospital bedside, in a nursing home or in a patient’s home, is the holy grail of healthcare. The thing we all value the most is the human to human connection. It’s that time when a person with special skills and knowledge is focusing on me, my health, my problems, and taking care of ME. And from the perspective of health care providers in every setting, anything that takes time away from that encounter can easily seem less meaningful, less important.

It wasn’t just what my friend said. I have heard similar comments over the years from many people working in healthcare. CEOs, administrators, physicians, nurses… everyone is overwhelmed by the roles and responsibilities and programs that have to be juggled and managed in order to stay viable in the complex world of healthcare.

So here’s the question I have been asking myself, after more than 22 years in quality improvement. Is the work that we do, or the work of other partner organizations, who ask providers to participate in a stream of quality improvement initiatives, or to change how they are providing care, or implement health information technology, or collect and share data on quality measures… is all of this “everything but” patient care?

I don’t think so. I think it IS patient care. I believe it’s what I as a patient expect providers and practitioners to know, and practice and bring with them, along with their formal training and education, when I put myself in their care. When I, or my family members or friends, enter the healthcare system, I believe it’s best for all of us—both providers and patients—when strategies for engaging patients as partners in their care so health outcomes are better are employed. It’s better for all of us when healthcare is coordinated and patient-focused across the continuum. And I think it’s better for all of us if providers know where their practice strengths and weaknesses are, where their systems fail, so that they can improve in areas that need improving.

But I do recognize that the number of new quality initiatives and requirements rolling out to the provider community on a continual basis is staggering. Rather than being helpful, the volume, complexity, and duplication overwhelms and confuses. So the onus is on us, as the organizations leading these programs, to work together to coordinate, consolidate, and simplify to maximize provider participation and uptake. The good news is we have a strong history of collaboration in North Dakota, with great examples of organizations working together around common goals. If any state can get this done, we can.

We continue to be encouraged and energized by the dedication and commitment to providing high quality healthcare that we observe on a daily basis from the people in the provider community doing the work. Despite significant challenges, North Dakota continues to be a high quality state, and our providers are always looking to do more to provide high quality care to the people in their communities.

Lastly, I want to say thank you to all of you who have said “yes” when we’ve asked you to participate in a quality initiative with us, or serve on an advisory group, or participate in some way with your work. Your dedication to healthcare shows. Going forward QHA will be here to partner with you, to assist you, and to continue to play a role in helping you make the care in our state the best it can be.
Here to Help

FirstLink provides resources for those in need

The various services offered by FirstLink branch out like a tree. There is never a dull moment for the 10 full-time and 10 part-time employees, and there are no two days that are the same. It can be hard to describe the organization to someone unfamiliar with it, but the name FirstLink really says it all.

“Our mission is to link people with resources, 24 hours a day,” says Executive Director Cindy Miller. As simple as the mission sounds, it’s a huge undertaking.

FirstLink operates the suicide helpline, 1.800.273.8255 (TALK), for North Dakota and Clay County, Minn., part of a national network of suicide helpline call centers. All calls to the helpline from 701 or 218 area codes are received by FirstLink’s call specialists, who work to ensure callers get the help and attention they may need. This can involve a wide variety of things, from helping a caller to find community resources, contacting emergency dispatch, and sometimes even just listening.

“It’s amazing how often people will de-escalate and feel better when they have been able to tell their story and share things with people,” says Miller.

Suicide awareness and education is a large priority for FirstLink staff, as well. In varying degrees, the half-day safeTALK, eight-hour Mental Health First Aid, and two-day Applied Suicide Intervention Skills Training courses all work to dispel myths, identify indicators, and better prepare attendees to recognize and help someone at risk of suicide. In 2016, FirstLink had more than 5,000 participants in training sessions. As the awareness level has risen and stigma has begun to be reduced, participation numbers have grown, an excellent sign of the community embracing the need to help others.

FirstLink has partnered with hospitals and in-patient psychiatric facilities across North Dakota for the Suicide Follow Up Program. Through the program, individuals who have attempted suicide or who have had suicidal ideation are contacted within 24 hours of leaving the facility. The calls empower and motivate individuals to use resources available to them and to let them know that FirstLink is there for them at any time. Subsequent calls may be made, sometimes for several months, to ensure the individual is doing well. Additionally, Caring Cards are sent to the individual’s home with a message of hope and support from FirstLink.

FirstLink also handles calls to 211 for North Dakota and Clay County. 211 is the national helpline for resource assistance, helping to provide information to callers about local assistance for housing, utilities, crises, food, health, and much more.

Incoming calls are placed into one of four categories: listening and support, information, crisis intervention, and referral. The categories are used primarily for internal purposes, as any need for the caller may prove crucial.

“For us, maybe it’s just a resource call,” says Jennifer Illich, director of helpline operations. “But for the person on the other line, it’s really a crisis.”

FirstLink’s call specialists handled 50,000 calls in 2016, connecting people with vital resources 18,000 times — incredible numbers considering the organization’s size. The credit goes to the dedicated staff.

“Our employees definitely have a love for the mission and vision that we have and they really care about people in the

Suicide Helpline: 1.800.273.8255 (TALK) – support and emergency coordination for individuals experiencing suicidal thoughts.

2-1-1: 211 or 701.235.7335 (SEEK) – Information, referral, emotional support, volunteer opportunities, and more.

FirstLink also provides after-hours call coverage for 17 other organizations.

Follow Up: Partnership with hospitals and in-patient psychiatric facilities throughout the state to stay in contact with recent suicide-related patients for support.

Training & Ed:

• Applied Suicide Intervention Skills Training (ASIST) - two-day workshop for all community members.

• safeTALK - half-day alertness workshop to prepares anyone over the age of 15 to become a suicide-alert helper.

• Mental Health First Aid - 8-hour course on how to help someone who is developing a mental health problem or experiencing a mental health crisis.

Disaster coordination: Volunteer coordination for Cities of Fargo, Moorhead, and West Fargo, and the Counties of Cass and Clay during disaster situations, such as flooding.

Giving Tree 2016 stats:

13,962 gifts collected
3,526 individuals within 1,474 families received gifts
$349,050 worth of gifts collected
community,” says Miller.

In addition to staffing resource helplines 24/7, FirstLink also serves as a hub for volunteering — both for organizations seeking volunteers and for people looking to volunteer their time. FirstLink currently partners with Impact Foundation to help match general needs with volunteers, and also provides volunteer coordination services for disaster situations in the Fargo-Moorhead area. As an organization, FirstLink has become a veteran of flood defense efforts.

During flood situations, FirstLink employees help coordinate volunteer efforts by fielding calls and providing employees to help coordinate volunteers at transportation and sandbagging stations. Though they’ve gained plenty of first-hand experience with flood situations, FirstLink is involved in regular tabletop exercises with city emergency management officials to remain prepared for any disaster.

On top of all this, FirstLink also runs the annual Giving Tree of Hope in Cass & Clay counties, collecting gifts for disadvantaged children and adults with special needs who would not otherwise receive gifts during the holiday season. This multifaceted organization has become a staple of the community and the state as a whole.

“We are so blessed to have a community that cares,” Miller says.
Prenatal exposure to alcohol, tobacco, and illicit drugs has the potential to cause a wide spectrum of physical, emotional, and developmental problems for these infants. Nationally each year an estimated 400,000-440,000 infants (10-11% of all births) are affected by prenatal alcohol or illicit drug exposure. In 2013, 795 children were diagnosed with Fetal Alcohol Spectrum Disorder in North Dakota. FASD is more prevalent than Down Syndrome, muscular dystrophy, and is as common as autism spectrum disorder.1 The harm caused to the child can be significant and long-lasting, especially if the exposure is not detected and the effects are not treated as soon as possible.2

Following a multi-year review and analysis of existing policies and practices, the National Center on Substance Abuse and Child Welfare developed a five-point intervention framework to address the system surrounding substance exposed newborns. This framework serves as a comprehensive model that identifies five major time frames when intervention in the life of an infant can help reduce the potential harm of prenatal substance exposure. The framework illustrates that birth is one of many opportunities to positively affect intervention outcomes. Therefore, it is important to understand the extent of those opportunities and which interventions are most needed and most likely to be effective at each point in time.

Five Point Intervention Framework Overview

Including excerpt recommendations from the North Dakota Task Force on Substance Exposed Newborns report to ND Legislative Management 3

1. Pre-pregnancy: During this time, interventions can include promoting awareness among women of child-bearing age and their family members of the effects that prenatal substance use can have on infants.

   • Recommendations:

   o Develop education materials and an awareness campaign to educate women of childbearing age, as well as their significant others and families, about the dangers of substance use/abuse during pregnancy.

   o Health care providers should be informed of, and encouraged to refer patients of childbearing age with substance abuse concerns to addiction treatment resources.

2. Prenatal: During this time, health care providers have the opportunity to screen pregnant women for substance use as part of routine prenatal care and to make referrals that facilitate access to treatment and related services for the women who need these services.

   • Recommendations:

   o Medical providers who provide services to pregnant women should understand their responsibilities surrounding testing, referral, follow-up and reporting.

   o Medical providers should develop consistent protocols for universal screening and testing of pregnant women.

   o Medical offices that provide care to pregnant women should develop protocols to identify patients who might be substance users/abusers and schedule appointments for them early in their pregnancies so they can receive information on the dangers of substance use/abuse as soon as possible.

   o Medical providers should provide best practice care to patients who are substance users during pregnancy (i.e. create a standard of care for pregnant mothers with an opioid use disorder be prescribed buprenorphine).

3. Birth: Interventions during this time include health care providers testing newborns for prenatal substance exposure at the time of delivery.
• Recommendation:
  o Medical providers should develop consistent protocols for universal screening and testing of newborns.

4. **Neonatal**: During this time, health care providers can conduct a developmental assessment of the newborn and ensure access to services for the newborn as well as the family.

• **Recommendations:**
  o Hospitals and social service agencies should partner in the development of plans of safe care for each newborn born with prenatal exposure to substances, prior to discharge from the hospital following the birth.
  o Parents and caregivers (including foster parents) should receive training and educational materials on best practices for caring with a newborn born with prenatal exposure to substances prior to discharge.

5. **Throughout childhood and adolescence**: During this time, interventions include the ongoing provision of coordinated services for both child and family.

• **Recommendation:**
  o County social services and direct service providers need training so they can better inform foster parents about care for children born exposed to substances. Social workers also need appropriate education materials and training presentations that they can offer to foster parents.

The ND Task Force on Substance Exposed Newborns, 2016 Summary of Recommendations can be found here: http://www.parentslead.org/sites/default/files/NDTaskForce-SubstanceExposedNewborns.pdf

This five-point intervention framework highlights opportunities for cross-system collaboration and policy development at each critical point in time, from pre-pregnancy throughout an infant’s early years. The framework also integrates recommendations for best practices related to outreach, engagement, treatment, and support for mothers and their infants along the five-point continuum. The framework shows that no single system has the necessary resources, information, or influence needed to adequately serve this vulnerable mother-infant dyad and other involved family members who are likely to need services. All those who have a role in improving outcomes for such families need to collaborate in order to put the necessary policies and practices in place. These collaborations can set the stage for maternal recovery from substance use disorders, child safety, and the well-being of all those involved.

Without a comprehensive coordinated response that includes child welfare and healthcare—including obstetrics, pediatrics, substance abuse treatment, and mental health professionals—families are not well served. Cross-system initiatives lead to better results by facilitating better communication, clearly defining the roles of the various professionals who serve these families, and maximizing the resources of multiple stakeholders who have a vested interest in accomplishing shared goals.  

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1 Burd, PhD, 2016. A Report to the North Dakota Task Force on Substance Exposed Newborns: From North Dakota Fetal Alcohol Syndrome Center.
3 Senate Bill 2367 in the sixty-fourth Legislative Assembly created a task force on substance exposed newborns “for the purpose of researching the impact of substance abuse and neonatal withdrawal syndrome, evaluating effective strategies for treatment and prevention and providing policy recommendations.”
Nursing Education Loan Program

Below are highlights of the Nursing Education Loan program.

- To the extent funds are available the education loans will be made in the following amounts:
  - $1000 for the non-degree licensed practical nurse student.
  - $2000 for the associate degree practical nurse student and the associate degree registered nurse student.
  - $3000 for the baccalaureate registered nurse student.
  - $4000 for the master’s degree in nursing including the post-master’s certificate.
  - $5500 for the doctoral graduate student.
  - Refresher course students may receive a loan of not more than the cost of the course.
- The funding for the program is $10.00 per renewal fee which typically amounts to approximately $70,000 - $80,000 annually.
- Applications are accepted annually beginning March 1st with a deadline of July 1st.

- The awards are made annually and reapplication may occur annually if the applicant has not received the total loan amount.
- The awards for undergraduates are disbursed from the Board of Nursing to the financial aid office in one payment each fall (or upon acceptance into the nursing program), for distribution to the recipient as determined by the financial aid office.
- The awards for the graduate students are made directly to the recipient.
- No changes have been made to the repayment portion of the program.
- A recipient receives $1.00 credit toward repayment of the loan for every hour they are employed in nursing in the state of ND after program completion.
- Our records indicate a vast majority of nursing education loan recipients take advantage of this option, and do remain in the state of ND for employment after graduation.
- Application forms are available on the North Dakota Board of Nursing website at https://www.ndbon.org/Education/NursingEdLoan/Overview.asp.

Nursing Education Loan Disbursements Per Fiscal Year

The following table identifies the nursing education loan disbursements by program type and monetary awards for the last five years.

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<td>11 $10,550</td>
<td>9 $13,600</td>
<td>4 $5,760</td>
<td>1 $650</td>
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<td>RN Baccalaureate Degree Program</td>
<td>31 $32,330</td>
<td>14 $19,300</td>
<td>16 $32,950</td>
<td>12 $25,386</td>
<td>16 $28,943</td>
</tr>
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<td>Master's Degree Program</td>
<td>23 $36,358</td>
<td>14 $19,300</td>
<td>16 $32,950</td>
<td>12 $25,386</td>
<td>16 $28,943</td>
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<tr>
<td>Doctoral Program</td>
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<td>12 $18,400</td>
<td>8 $21,000</td>
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<td>0</td>
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<td>68 $83,700</td>
<td>56 $100,190</td>
<td>53 $92,510</td>
<td>49 $81,542</td>
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Volume 2 • Issue 2
North Dakota Acute Stroke Ready Hospital Designation

Shila Thorson, ND State Stroke & Cardiac System Coordinator

The North Dakota Stroke System of Care’s purpose and mission is to create and maintain an inclusive and coordinated statewide system of care and education that continuously improves knowledge, diagnosis, treatment, and rehabilitation of stroke patients and reduces the overall stroke risk for all North Dakota citizens. The system promotes timely, high-quality care to acute stroke patients. A part of supporting our mission is ensuring hospitals in the state provide appropriate and timely care for stroke patients. Stroke designation is a method of recognizing the hospitals that meet specific standards to ensure better outcomes for stroke patients.

Currently, North Dakota recognizes three levels of stroke designation: Comprehensive Stroke Center, Primary Stroke Center, and Acute Stroke Ready Hospitals. The Joint Commission offers certification for all three levels that our state recognizes, however, North Dakota also has a state designation certification for Acute Stroke Ready Hospital status. Currently, North Dakota has no hospitals designated as Comprehensive Stroke Centers, the highest level of certification designed to recognize the specific capabilities of hospitals that can treat the most complex stroke cases. All six tertiary hospitals in the state are designated as Primary Stroke Centers. The Joint Commission recognizes these facilities as making exceptional efforts to foster better outcomes for stroke care and can meet the unique and specialized needs of stroke patients. Acute Stroke Ready Hospital designation is the basic level of stroke designation in the State of North Dakota. The Acute Stroke Ready Hospital designation indicates the hospital has the proper resources to diagnose, stabilize, and provide definitive care to acute stroke patients before transferring them on to a higher level of care, such as a Primary or Comprehensive Stroke Center. Currently, 27 Critical Access Hospitals are designated as Acute Stroke Ready Hospitals, with three additional hospitals awaiting determination at the upcoming Stroke Task Force meeting. Some facilities in North Dakota do not meet designation criteria. These facilities continue to be an important part of the stroke system as often patients may walk in or arrive by privately owned vehicle. Facilities that are not designated need to continue to have protocols in place to identify stroke and rapidly transport to a designated stroke hospital.

Initially, hospitals that met the criteria are required to complete and submit a designation application to the North Dakota Department of Health. If the department approves the application, the facility receives a one-year provisional stroke designation. After one year, the facility will be required to complete a site visit to retain designation. Upon completion of the site visit, the health department will determine a designation length of up to three years to the facility. The facility will be required to reapply for designation during the last year of the designation period.

The North Dakota Stroke System of Care Taskforce developed the requirements for Acute Stroke Ready Hospital designation in 2015. They based the criteria on the 2013 recommendations from the Brain Attack Coalition, a group of professional, voluntary, and governmental organizations dedicated to setting direction, advancing knowledge, and communicating the best practices to prevent and treat stroke. An Acute Stroke Ready Hospital (ASRH) has the capability to care for acute stroke patients, including completing blood tests and administering intravenous tissue plasminogen activator, or “tPA.” These facilities have a CT scanner and the ability to perform the CT and read the results within 45 minutes of a test. The facility must also meet other requirements including staff response times, education, treatment guidelines, quality improvement, and data collection through the North Dakota State Stroke Registry. The ASRH should make a goal of transferring an acute stroke patient within two hours of emergency department arrival, or once medically stable, whichever comes first.

In conjunction with hospital designation, the Division of Emergency Medical Systems now includes transport plans as part of the application packet for ground ambulance service licensure. The purpose of these transport plans, which include stroke, is to have ambulance services well prepared for and know where they should be transporting patients in certain situations and from certain areas within their service area. Patients with time critical conditions are better served when these plans are set in place before the emergency takes place. Each area’s transport plans will look different and may include a bypass of hospitals if that is what is most beneficial to the patient. Once received by the Division of Emergency Medical Systems, the task force for each time critical condition reviews the transport plans. The North Dakota Stroke Task Force will be responsible for the review of the stroke transport plans.

For more information on hospital designation or to see the complete list of designated hospitals, please visit https://www.health.nd.gov/epr/emergency-medical-systems/stroke-system/. For further questions, please feel free to contact, Shila Thorson, State Stroke & Cardiac System Coordinator at smthorson@nd.gov.
The ND Cares Coalition includes a broad spectrum of more than 45 military and civilian professionals dedicated to the support of North Dakota Service Members, Veterans, Families, and Survivors (SMVFS).

The coalition uses the broadest definition of Veteran and is working to encompass all individuals who are currently serving or who have served – the “total force.”

ND Cares is not a provider of services; rather, it is dedicated to improving understanding of the needs and services required by our SMVFS.

The purpose of ND Cares is to resolve barriers or gaps in services to ensure those serving and those who have served, their families, and survivors receive the care and assistance they need.

One of the ways the group has proposed making the subject of service member support more visible within the state is through the ND Cares Community Program. The Coalition’s vision is to have each of North Dakota's cities place an ND Cares road sign on main arteries running into their communities. The displays are intended to let the public know that North Dakota residents are committed to promoting a sanctuary of care and outreach for those who have served and their families.

With statewide support, the ND Cares coalition hopes to reach the more than 52,035 North Dakota residents who identify themselves as veterans of the U.S. Military. According to the U.S. Census Bureau’s 2012 American Community Survey, this group accounts for 10 percent of the state’s adult population.

In December 2015, the historic tourist town of Medora became the first city to pledge itself as a ND Cares community. It now has four ND Cares signs prominently displayed on each of its main roadway entrances. Carla Steffen, Medora’s city auditor, said the process towards becoming an ND Cares community developed rapidly. She attended an ND Cares presentation given at the ND League of Cities convention in 2015. There, attendees were provided information about the state’s veteran population and the challenges they face, and city leaders were encouraged to participate as ND Cares community members. Steffen brought the information back to Medora’s October 2015 City Council meeting, and participants agreed to undertake the initiative immediately.

As an ND Cares Community, cities must host an annual event to honor service members, veterans, families and survivors. Medora was already hosting an event within the city, during its Cowboy Christmas event in early December. To set the ND Cares program in motion, members of Medora’s City Council asked the event’s planners to be their local ND Cares steering committee.

Since Medora, thirty more North Dakota cities have followed in becoming ND Cares communities. In West Fargo, Mayor Rich Mattern hosted a ceremony consisting of a color guard from the local veterans groups, reciting the Pledge of Allegiance, "The Star Spangled Banner" sung by Mrs. Beckers’ 4th grade class, speeches by the First Lady Betsy Dalrymple; Major General Dohrmann; North Dakota Adjutant General and Mayor Mattern, a Q & A with attendees and press, and finally the presentation of the ND Cares Certificate.

“The idea is to make sure that veterans, families, survivors and service members don’t fall between the cracks,” Mattern
said in an article written by the West Fargo Pioneer. “If they need support, the city will do what it can to steer them in the right direction to receive help.”

Dohrmann thanked the cities leaders and service organizations for their dedication to military members, veterans and families.

“For the North Dakota National Guard, our readiness has to be our top priority. Our Soldiers and Airmen are, as we say, ‘always ready, always there’ to perform missions in support of our communities, state and nation,” he said. “But we rely on the support of our families, friends and neighbors as well. By becoming an ND Cares community, you are strengthening your commitment to our Guardsmen and ensuring they build resiliency and receive any resources they may need to maintain their readiness and respond when our state needs them.”

What’s next? ND Cares in conjunction with the ND Department of Health will be hosting Star Behavior Health Training. The Star Behavior Health Training Program is a 3-tier evidence-based training which focuses on the needs and challenges of military service for both the service member and his or her family. This training will be conducted in Bismarck, April 11-13 and May 9-10, 2017.

For more information about the ND Cares Community Program, contact ND Cares Executive Director Darcie Handt at 701-333-2012 or email ndcares@nd.gov.

ND Cares was established by a Governors Executive Order in 2015. The ND Cares coalition includes a broad spectrum of more than 45 service providers and partners whose work touches the lives of service members, veterans, families and survivors. Members share a common interest in strengthening an accessible network of support across the state, even though each entity retains authority over its own programs and services. The purpose of the ND Cares coalition is to resolve barriers or gaps in services to ensure those who have served — and their families and survivors — receive the care and assistance they need.
Five Ways to Optimize Your Supply Chain
By Lori Pilla, Vice President, Intalere Clinical Advantage and Supply Chain Optimization, and Shannon Wheeler, Project Manager, Benchmarking and Analytics

Today’s market dynamics, coupled with healthcare reform measures, have made supply chains extremely complex and planning more difficult. Representing 25 percent of a healthcare provider’s budget, the supply chain holds significant opportunities for savings. That’s why it’s critical for providers to reduce high-dollar supply chain inefficiencies. Implementing a supply chain optimization strategy takes a great deal of work and great effort on the part of the organization. However, the benefits far outweigh the efforts because an optimized supply chain can help a facility stay lean, manage costs and respond to fluctuations in demand.

Here are five ways to optimize your supply chain:

1. Take Control of Your Item Master

At the core of a supply chain management data architecture is the facility’s item master and the taxonomy of the medical items. The item master is your organization’s information source for some of the most important supply chain activities – procurement, charge master comparison and/or linking, data standardization and value analysis. If this data is disorganized and contains errors, then it will be very difficult to improve operations and control costs in your facility. The fact that there are likely multiple sources entering information into your materials management information system (MMIS) without standardized rules can often lead to the following:

• Duplicate entries.
• Inconsistent item descriptions.
• Inconsistent and obsolete manufacturer names.
• Outdated manufacturer item numbers.
• Missing or outdated categorization schemes,

Table 1 is an example from an organization’s item master that shows three unique entries for the same item. The vendor name, item description and part # are all inconsistent. It’s easy to see how your facility’s item master could get out of control without the proper rules established.

Streamlining the item master will help your organization attain transparency of your supplies and support trending of utilization. It’s a necessary step to developing an integrated supply chain management system that aims to reduce costs, improve efficiency and enhance patient safety and clinical outcomes.

2. Manage Your Inventory

Inventory plays a vital role in supply chain optimization. Efficient management of inventory is no easy task though. It’s a challenge to balance the right amount of supply to meet the facility’s demands. For example, having a high amount of inventory results in increased storage costs and a chance of product expirations; having a low amount of inventory is risky due to the impact it can have on patient care if products are not available.

Examine your business processes in the areas of supply procurement, patient charging, inventory management and information capture. Look for ways to improve and/or automate certain functions. You might discover your staff is spending too much time dealing with inventory, when they could be focusing on patient care instead. In this era of strict payment regulations, any breaks in your processes can lead to time-consuming resubmission efforts, penalty charges and lost or inaccurate revenue.

You are on the path to success if your facility is able to connect your inventory management data with your relevant procedural data. Gaining this visibility will give you meaningful insights to improve clinical care, staff and resource utilization and cost control.
Five Ways to Optimize Your Supply Chain

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3. Establish Supply Chain Metrics for Measurement and Benchmarking

It has often been said, “You cannot improve what you do not measure.” Benchmarking encourages a company to become open to new methods, ideas, processes and practices to improve effectiveness, efficiency and performance. By benchmarking you may discover who performs the process best within your own organization or outside of your industry.

Establish supply chain key performance indicators (KPIs) and involve key stakeholders throughout the benchmarking process. Reviewing these KPIs consistently as a team will stimulate thought provoking discussions and help your facility stay on target to reach the business goals of the organization. Remember that your benchmarking efforts should not stop once you’ve reached the goals you establish. Constant monitoring and measuring leads to ongoing success.

Table 2 is an example of supply chain KPIs.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Better Performing (75%)</th>
<th>Median (50%)</th>
<th>Poor (25%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supply Chain Expense per Adjusted Patient Day</td>
<td>$236</td>
<td>$321</td>
<td>$399</td>
</tr>
<tr>
<td>Supply Chain Expense per Adjusted Discharge</td>
<td>$754</td>
<td>$998</td>
<td>$1,250</td>
</tr>
<tr>
<td>Supply Chain Expense as a % of Operating Expense</td>
<td>13%</td>
<td>17.15%</td>
<td>19.3%</td>
</tr>
<tr>
<td>Supply Chain Expense per Surgical Procedure</td>
<td>$803</td>
<td>$1,220</td>
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</tr>
<tr>
<td>Pharmacy Expense per Adjusted Discharge</td>
<td>$116</td>
<td>$160</td>
<td>$183</td>
</tr>
</tbody>
</table>

Analysis prepared by American Healthcare Solutions (powered by MDR). For further information contact Shannon Wheeler at shannon.wheeler@Intalere.com.

4. Create a Value Analysis Committee

Organizations can no longer afford to have physicians make all the purchasing decisions. The never-ending pressure to contain costs and optimize patient care has led many facilities to create a new decision-making process – one that involves a cross-functional team.

In order to make best-valued product and service acquisition decisions it’s crucial to create a value analysis committee (VAC). This committee should involve key stakeholders in the following areas:

- Clinicians to bring product knowledge and valuable evaluation opinions.
- Finance to bring cost analysis knowledge.
- Materials managers to bring supplier management and contracting knowledge.

The structure and processes of a VAC can vary by organization. To be successful, make sure your VAC is in agreement on these key objectives:

- Collaborate using a team approach.
- Focus on quality, safety, costs and performance improvement.
- Use an evidence-based approach to evaluate new and emerging technology.
- Standardize on products that are clinically successful and provide the highest quality care and safety to patients in the most cost-effective manner.

5. Implement Performance Improvement Analysis

At the forefront for most healthcare organizations is the goal to improve the patient experience without sacrificing quality and lowering costs. Healthcare reform doesn't allow providers the luxury of relaxing after achieving a goal. Areas of focus for process improvement within the healthcare supply chain are constantly changing. Purchasing, receiving, inventory management, distribution and other hospital-based functions are being replaced out of necessity with sourcing, acquisition, logistics, collaborative contracting, cost management and relationship building with key partners such as physicians, suppliers and the community.

Your facility should consistently evaluate and review your systems and processes. Changes to your organization and the industry often open possibilities to become more efficient. You can capitalize on this by making thoughtful and informed decisions. Effective decisions regarding your supply chain begin with an analysis of your requirements and expectations.

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