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LEAN, CLEAN, & CLOSE TO HOME

The CentraCare Dialysis Center provides a comfortable and safe environment for patients and providers to create the optimal path for individualized renal care. JLG’s designed the satellite clinic to easily translate to other white box spaces so that CentraCare can always be close to home.
Welcome to Insight

This Fall issue of “Insight” is being published as we gather in Fargo for the North Dakota Hospital Association 83rd Convention and Annual Business Meeting on October 3. Over the last few years we have made a number of changes to the convention. Moving the convention to Fargo a few years ago was a big step. It has worked well and our attendance has grown each year. This year is no exception when it comes to change. On Monday and Tuesday, the 42nd Annual Update Conference - an educational event co-sponsored by NDHA subsidiary HSIsolutions - will take place. The NDHA Convention and the Update Conference will overlap for one day and share some of the educational programs as well as a keynote presentation that will wrap up the Update Conference and kick off the NDHA Convention. In 2018, we will combine the two events to run simultaneously and move to the Holiday Inn in Fargo.

In the Spring issue, I touched on the progress of the 2017 legislative session. We were about halfway through the session then and we were at the Capitol everyday working on key bills. The most significant issue was the reauthorization of Medicaid Expansion. As you are all aware, we were successful and Medicaid Expansion was re-approved until July 2019. Not only did we get the program reauthorized, we also successfully fought for continuing commercial rates. Again, getting this legislation passed took a lot of team work and I want to thank each of you for stepping up this session.

We thought after the votes to repeal the Affordable Care Act (ACA) were defeated this summer we had heard the last of repeal and replace. However, as I write this, the Senate is taking one last run at repealing the ACA - this time with the Graham-Cassidy-Heller-Johnson proposal. If the Senate fails to pass this legislation with 51 votes by September 30, they will need 60 votes. Senators could write new instructions for their next budget, but they were planning to use that opportunity for a different legislative priority — tax cuts. And the Senate considers only one legislative priority at a time under the reconciliation process. So the Republican caucus in the Senate is pushing to get it passed before the deadline. We are not sure what the passage of the bill means at this time as the Congressional Budget Office (CBO) has not scored it yet. We do have, however, information from those supporting and those opposed. As you can guess, they are far apart. We will know more by the time the Convention starts. Stay tuned. The excitement does not end.

Jerry Jurena, President
ND Hospital Association

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Insight Submission Policy
The ND Hospital Association is pleased to accept submissions for Insight. Submissions should be reasonable in length due to space considerations. In order to ensure the quality of our publication, editing for grammar, spelling, punctuation and content may occur. Articles, photos, and advertising should be submitted in electronic form.

To submit, please email NDHA at: pccook@ndha.org
The deadline for the Spring Issue is April 4th, 2018
Proposed Changes to 340B Drug Pricing Program

By: Melissa Hauer, General Counsel, NDHA

The 340B Drug Pricing Program has allowed certain hospitals and other health care providers to obtain discounted prices on “covered outpatient drugs” (prescription drugs and biologics other than vaccines) from drug manufacturers. Manufacturers must offer discounts to hospitals in order to have their drugs covered under the Medicaid program. Estimates show that hospitals saved $3.8 billion on outpatient drugs through the program in fiscal year 2013. The intent of the 340B program is to allow certain providers to stretch scarce federal resources as far as possible to provide more care to more patients. Although the ceiling prices are proprietary, it is estimated that, on average, hospitals in the 340B program receive a minimum discount of 22.5 percent of the average sales price for drugs paid under the Outpatient Prospective Payment System (OPPS).

On July 13, 2017, the Centers for Medicare & Medicaid Services (CMS) proposed, as part of its Calendar Year 2018 update to the OPPS, to reduce payment for drugs purchased under the 340B Drug Pricing Program to ASP minus 22.5% rather than the current rate of ASP plus 6%. This is projected to reduce Part B drug payments to 340B hospitals by $900 million. This reimbursement cut of approximately 30% in the aggregate would significantly reduce the savings available to 340B participating providers.

NDHA is concerned, not only with this significant cut, but also that the pricing methodology will set the market with private insurers if they react by following Medicare’s example and reducing drug payments. The proposed rule punitively targets 340B safety-net hospitals serving vulnerable patients, including those in rural areas while doing nothing to address the real problem: rising drug prices. We believe the current 340B program should be maintained. We strongly urge CMS to abandon this 340B proposal and instead take direct action to halt the unchecked, unsustainable increases in the cost of drugs. NDHA also urged the U.S. House Ways and Means, Health Subcommittee (see article on p. __), to examine the proposed cut as part of its Medicare Provider Statutory & Regulatory Relief Initiative.
EXPANDING QUALITY CARE SERVICES TO THE SURROUNDING COMMUNITY

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Time to Consider All Ideas to Lower Healthcare Costs

By: Representative Kevin Cramer

In my nearly five years representing North Dakota in Congress, it has been clear from the start that North Dakotans are suffering under Obamacare. As I travel the state, I hear from many folks who pay $500 or more a month in premiums and have $10,000 plus deductibles for “insurance” they can’t afford to use. In North Dakota, our farmers and ranchers, who generally purchase health insurance through the individual market, have been hit particularly hard by the ravages of Obamacare.

Even so, as recently demonstrated, it seems some Members of Congress do not have any will to do comprehensive healthcare reform. That is why I am suggesting Congress take up "rifle shot" standalone bills in an effort to improve healthcare, one piece of legislation at a time. The House and Senate should bring up individual policies and hold committee hearings so the public can participate in the debates more thoroughly. After a hearing, Congress should then hold a vote on each idea so Members cannot cite one idea they don’t like as a reason to kill an entire healthcare reform effort. This process would make it more difficult for obstructionists to hide their motives and put Members on record on where they stand on certain principles.

With this idea in mind, it is important to note the House has already passed many noteworthy healthcare bills this year. These bills include:

- H.R. 372, the Competitive Health Insurance Reform Act, ensures health insurers are subject to the same antitrust and unfair trade practice laws with which all businesses comply. This includes prohibiting businesses from engaging in price fixing, bid rigging and market allocation which drive up healthcare costs for consumers.

- H.R. 2579, the Broader Options for Americans Act, provides tax credits to people who recently lost their jobs to continue using their employer insurance while getting back on their feet.

- H.R. 1215, the Protecting Access to Care Act, sets reasonable limits on damages and ensures plaintiffs can actually recover full medical costs. Medical liability lawsuits cost the healthcare system as much as $300 billion each year.

- H.R. 1101, the Small Business Health Fairness Act, allows small businesses to join together in association health plans across state lines to purchase cheaper insurance.

It is hard to fathom why some in Congress would be against ideas such as allowing small businesses to pool their capital to purchase cheaper insurance for their employees. Unfortunately, Senate Democrats have been holding up these bills from being considered on the Senate floor.
In addition to the bills already passed by the House, other standalone ideas Congress should consider include:

- Repeal or delay the 96-Hour and Direct Supervision Rules. Relieving rural hospitals from cost-intensive and senseless regulations would lower healthcare costs for 60 million Americans who rely on rural facilities for health service.
- Allow individuals to deduct their healthcare costs from their taxes, just like employers do.
- Reform Health Savings Accounts by doubling the amount people can save tax free and allowing the money to be spent on more services and products.
- Allow folks to purchase insurance across state lines.
- Require greater price transparency for healthcare services so patients can shop around for the best prices for procedures and examinations.
- Repeal the individual mandate which forces people to buy insurance that does not work for them.
- Strengthen the National Institutes of Health to lower costs. There are 10,000 known diseases and we only have treatments for 500 of them. Cures for diseases up front means significantly lower treatment costs on the back end.
- Allow states to refine Medicaid to better meet the needs of their unique populations. States understand their people better than Washington, D.C.
- Repeal the 96-Hour and Direct Supervision Rules. Relieving rural hospitals from cost-intensive and senseless regulations would lower healthcare costs for 60 million Americans who rely on rural facilities for health service.

These are just a few ideas offering great potential to improve healthcare in the United States. If we view the problems in the American healthcare industry with a clean slate, we can seriously consider what ideas may drive down costs for patients and the government and improve care.

As a member of the House Energy and Commerce Committee, which has primary jurisdiction over healthcare policy, I welcome input from all of my constituents, including our North Dakota hospital professionals. I encourage you to reach out to me with your ideas, keeping nothing off the table. By moving forward, even if it’s one idea at a time, we can create a much better healthcare environment in America - for our hospitals, doctors, and ultimately, our patients.
The 65th Legislative Assembly of North Dakota began its regular session on Tuesday, January 3, 2017, and adjourned on Thursday, April 27, 2017. It was a challenging session as we worked with many new legislators and a new Governor to advance the goals of NDHA. Even though the political landscape changed, our focus remained the same - to create an understanding of healthcare needs and healthcare delivery in North Dakota and, ultimately, to promote the health of the people of our State. Our most pressing issues during this legislative session were reauthorization of the Medicaid Expansion program, Medicaid reimbursement, workforce, and behavioral health.

The 2017 legislative session could probably be best described as one of uncertainty. In April 2016, the Governor announced a reduction in spending of 4.05% for all agencies of state government and in September, he announced another reduction totaling 10% for selected agencies. And the revenue forecast in December was not optimistic. The North Dakota Department of Human Services appropriation bill, House Bill No. 1012, was the bill we spent the most time on. The issue of most importance in the bill was reauthorization of Medicaid Expansion and maintaining commercial rates. In the beginning, it looked like commercial rates were going to be reduced to traditional Medicaid rates which would have been a decrease of reimbursement from $542 million to $404 million for the biennium. With much effort from many groups, the bill passed and Medicaid Expansion was reauthorized and commercial rates were maintained.

Below is a summary of all of the significant bills that NDHA actively worked during the session.

- 2017 HB 1012. Medicaid Expansion. The North Dakota Department of Human Services appropriation bill included reauthorization of the Medicaid Expansion program for another two years and continued funding it at the current commercial rates. It also provides that legislative management shall consider studying options to operate Medicaid and other related programs as managed care.

- 2017 HB 1024. Medicaid Deficiency Appropriation. This bill provided a deficiency appropriation to the North Dakota Department of Human Services so that Medicaid claims made during the current biennium could be paid to providers. The House reduced the appropriation from the requested $9 million to $5 million. The full amount of $9 million was restored however in the final bill.

- 2017 HB 1371 and SB 2198. Medical Imaging/Radiation Therapy Licensing. These bills deal with licensing of medical imaging and radiation therapy personnel.

- 2017 SB 2231. Air Ambulance Service Providers. Before a hospital refers a patient to, or initiates contact with, an air ambulance service provider for air transport, the hospital must inform the patient or representative of the air ambulance service provider’s health insurance network status (in-network or out-of-network). A hospital fulfills this obligation if it provides the patient/representative the insurance network status published on the Insurance Department’s website. A hospital does not have to give the notice if it determines and documents that due to emergency circumstances, compliance might jeopardize the health or safety of the patient.

- 2017 SB 2312. EMS Personnel. This bill allows licensed advanced emergency medical technicians and paramedics who are employed by hospitals to provide patient care within a scope of practice established by the North Dakota Department of Health. This allows EMS professionals to work under the reporting structure that works best for the hospital (i.e., through the nursing structure or reporting to physicians).

- 2017 HB 1365. Guardians Making Medical Decisions. A guardian with general authority to make medical decisions on behalf of a ward also has authority to consent to involuntary treatment with prescribed medications. A guardian with limited
authority, however, may not consent to involuntary treatment with prescribed medications unless the court has made specific findings allowing it. Before consenting to involuntary treatment with prescribed medication, a guardian must get a recommendation from the treating provider that the proposed medication is clinically appropriate and necessary.

• 2017 HB 1096, HB 1097, HB 1157, and SB 2235. Licensing Compacts. These bills dealt with entering into compacts with other states for the expedited licensing of Advanced Practice Registered Nurses, nurses, physical therapists, and physicians to permit them to practice in all compact states. All of them passed with the exception of the physician licensing compact.

• 2017 HB 1039 and SB 2215. Hospital Discharge Policies. These bills would have required hospitals to establish written discharge policies that would have allowed a patient to designate an uncompensated caregiver. The bills mandated that hospitals notify the designated uncompensated caregiver of the patient’s discharge or transfer to another facility and that the hospital provide the patient and uncompensated caregiver “instruction and training” for the patient’s aftercare before the patient could be discharged. Both bills were defeated.

• 2017 SB 2234. Medical Marijuana. This bill made changes to the medical marijuana law passed by initiated measure in November 2016, to allow the Department of Health time to implement the regulation of the Compassion Centers that will grow and dispense the marijuana, to decriminalize possession of marijuana for registered users, to restrict the forms available, including a prohibition on minors smoking it, and to set the application fees for users and Compassion Centers.

• 2017 SB 2003. UND School of Medicine, NDSU and DSU Nursing Colleges. This bill provided $13.8 million for residency positions and included 16 new residency slots, 16 more medical students, and 30 additional health science students. It requires the State Board of Higher Education to study the reorganization of its nursing programs and present a plan to the next legislature to reorganize the nursing programs. Late in the session, an amendment was proposed to prohibit the spending of any funds for the NDSU College of Nursing at Sanford Bismarck. This amendment did not make it into the final bill. The bill also provides that Dickinson State University may not discontinue its nursing program.

• 2017 SB 2052. Telemedicine. This bill requires health insurers to provide coverage of health services delivered by means of telehealth. A health insurer may pay for covered telehealth services at a rate that is different than other covered services. It does not require coverage for health services that are not medically necessary or for services that are not covered if provided by in-person means.
Providing Quality Health Care for North Dakotans

By Senator John Hoeven

North Dakota is fortunate to have dedicated health care professionals who are committed to providing quality care to patients. Yet, increasing health care costs are unsustainable for families and businesses and we must do more to bring down costs while improving quality of care. With insurance premiums more than doubling since 2013 and North Dakotans bracing for double digit premium increases this fall, we must work to reform our health care system.

I appreciated the input of the North Dakota Hospital Association at health care roundtables I held this year, and welcomed our ongoing dialogue as the Senate worked to reform health care. We share the goal of providing quality health care to North Dakotans.

Throughout the health care debate, I maintained the following guiding principles. First, we need to give individuals and families more choices, not force them to buy one-size-fits-all policies. Next, we need to ensure coverage for those who truly can’t afford insurance by preserving Medicaid. Finally, we need to bring down the cost of health care by reducing burdensome federal regulations and empowering states to be innovative in their approaches to health care coverage.

The Senate voted on several bills this summer that would have started the process of reforming our health care system. These bills would have ended the individual and employer mandates and helped restore Americans’ ability to choose the health care coverage that best fits their needs. At the same time, they would have provided states with greater flexibility to innovate free from excessive mandates imposed by Washington.

I opposed the first version of the Better Care Reconciliation Act (BCRA) because it didn’t do enough to help low-income individuals have access to affordable health care coverage. However, the version that the Senate ultimately voted on was significantly different from the original draft. I worked with others to add more than $200 billion in a long-term stability fund and important Medicaid provisions to make sure low-income individuals would have coverage. Under the revised BCRA, North Dakota would have received a similar amount of resources as under the Affordable Care Act, but with more flexibility and a variety of new tools to meet the needs of patients. Between Medicaid, refundable tax credits, a long-term state stability fund, a new substance abuse treatment fund, and additional federal resources to cover the treatment of Native Americans, the state would have had the necessary tools to provide health care coverage for low-income individuals. At the same time, the legislation would have provided $50 billion to help stabilize the insurance market and make it more competitive so that consumers could have access to better, more affordable insurance policies. Further, the bill would have phased in over seven years, allowing states, providers and patients adequate time to adjust.

The Health Care Freedom Act would have repealed mandates, as well as the medical device tax for three years, increased the contribution limit for health savings accounts and provided greater flexibility to the states.
Importantly, it continued to fund Medicaid expansion and would have had no impact on traditional Medicaid.

Another bill the Senate considered – the Obamacare Repeal and Reconciliation Act – would have repealed portions of Obamacare, while continuing Medicaid expansion and insurance premium support payments to give Congress time to enact a replacement.

While none of these bills received sufficient support to pass, Congress continues working to reform our health care system.

To provide Americans some relief from increasing premiums, higher deductibles and fewer options under Obamacare, the HELP Committee is working to craft bipartisan legislation to stabilize the health insurance market and provide states with additional flexibility. At the same time, we need to repeal burdensome mandates and costly taxes.

Often, rural and frontier areas are disproportionately impacted by onerous regulations coming out of Washington. Regulatory challenges are also inhibiting providers from fully utilizing telemedicine, which can help increase access to care in rural areas.

I also look forward to continuing to work with NDHA to better meet our state’s behavioral health challenges, address workforce shortages, increase access to local care for veterans, support community health centers and ensure that the federal government fulfills its obligation to fully cover health care cost for Native Americans.

I appreciate the good work of our state’s health care providers and welcome your continued input as Congress works to reform our health care system and provide Americans with access to patient-centered health care and insurance at affordable rates.
What Makes North Dakota Great?

A simple question and one that has many correct answers. Clean air, open spaces, the people, four seasons (well!)…the answers are endless. If you ask HRET, the answer is likely to look more like dedication to improving healthcare, a strong work ethic, attention to detail, an understanding of what needs to be done, and teamwork. These descriptors have in fact been used by the American Hospital Association’s HRET HIIN leads to describe Innovate-ND – North Dakota’s HRET HIIN.

Innovate-ND|HRET HIIN Participating Hospitals

Ashley Medical Center
Carrington Health Center
Cavalier County Memorial Hospital – Langdon
CHI Mercy Health – Valley City
CHI St. Alexius Health Community Memorial Hospital – Turtle Lake
CHI St. Alexius Health – Devils Lake
CHI St. Alexius Health Dickinson Medical Center
CHI St. Alexius Health – Garrison Memorial Hospital
Cooperstown Medical Center
First Care Health Center – Park River
Heart of America Medical Center – Rugby
Jacobson Memorial Hospital – Elgin
Linton Hospital
McKenzie County Healthcare System – Watford City
Mountrail County Medical Center – Stanley
Nelson County Health System – McVille
Northwood Deaconess Health Center
Pembina County Memorial Hospital – Cavalier
Presentation Medical Center – Rolla
Sakakawea Medical Center – Hazen
Sanford Hillsboro Medical Center
Sanford Mayville Medical
Southwest Healthcare Services – Bowman
St. Aloisius Medical Center – Harvey
St. Andrew’s Health Center – Bottineau
St. Luke’s Hospital – Crosby
Tioga Medical Center
Towner County Medical Center – Cando
Trinity-Kenmare Community Hospital
Unity Medical Center – Grafton
Wishek Community Hospital
A recently published HRET HIIN newsletter depicted North Dakota as the leader in data collection and submission (97%). But, it didn’t stop there! North Dakota HRET HIIN participating hospitals were also noted as high performers. Over 97% of our hospitals are demonstrating improvement on 5–7 HIIN measures and 52% on 8 or more measures. Clearly, hospitals who are collecting and reporting data are using the information to drive improvement in their facilities. And, the descriptors used by HRET to describe Innovate-ND accurately characterize the HIIN teams in our HRET HIIN participating hospitals – the boots on the ground to drive improvement!

**SIX STRATEGIES THAT DRIVE IMPROVEMENT IN ND HOSPITALS**

**Executive Leadership Engagement**

Executive leadership engagement has long been regarded as a key driver in quality improvement and patient safety. CEOs from HRET HIIN participating hospitals in ND have demonstrated engagement in a variety of ways. This engagement has led to leadership inclusion and ultimately collaboration.

- Active participation in regional and site visits
- Allocation of time and resources for HIIN leads/teams in their hospital
- Share performance reports with their Board of Directors
- Have patient representation on their Board of Directors

**Multidisciplinary Team Approach to Performance Improvement and Patient Safety**

One is not a team. When it comes to patient safety and performance improvement, it takes a system-wide approach to affect meaningful and sustainable improvement. In critical access hospitals one person may wear several hats; but with a designated HIIN leader in place, increasingly ND hospitals, without respect to size and volume, are thoughtfully and deliberately including data collection staff, QI/PI staff, infection preventionists, staff educators, physician champions and others into their work.

**Patient and Family Engagement**

Innovate-ND has purposefully built a patient and family engagement component into each measure. White boards, bedside reporting, thoughtfully planned education materials, teach backs, and patient advisory councils are examples of strategies used to engage patients and families in many ND HRET HIIN participating hospitals.

Attention to unique factors that influence a patient’s outcomes further engage patients and their families in their care. Hospital HIIN teams are encouraged to directly ask patients, “What is your biggest concern about going home?” Interestingly, the responses often have little to do with their medical condition and include concerns such as access to pharmacy and food, being alone, and creating a burden for their family. The solutions to these concerns may lie outside the four walls of the hospital – in their community. Conversely, patients and their families may acknowledge the need for assisted living or long-term care but the real reason they don’t pursue it is because they haven’t adequately planned for this phase of their life and fear the cost of the next level of care; they don’t want to lose their independence; they don’t think their spouse should be left alone; they have a pet they can’t leave; etc. These concerns again highlight the need to think beyond the four walls of the hospital to innovatively identify solutions. Advance care planning is one of the solutions offered and encouraged to promote dialogue between patients and healthcare professionals.

**Efforts to Reduce Avoidable Readmissions**

Many HRET HIIN participating hospitals have set into motion a number of interventions to reduce avoidable readmissions. Using the HRET HIIN Readmission Change Package as a resource, they include,

- Early identification of extrinsic factors that could
possibly contribute to readmissions then innovatively finding solutions (again, thinking beyond the four walls of the hospital!). This is active Patient and Family Engagement!

- Detailed discharge planning that takes a look at the entire patient and helps determine where/how all their needs (bio, psycho, social and spiritual) will best be met.
- Community organizing, with specific intentions of identifying support and resources beyond the traditional healthcare framework.

Efforts to Reduce Falls

Falls, an unplanned descent to the floor, is a high priority in ND HRET HIIN participating hospitals. According to the Centers for Disease Control and Prevention (2015), “Among adults aged 65 or greater, falls are the leading cause of injury-related death, the most common cause of non-fatal injuries and the leading cause of hospital admissions for trauma.” Some notable interventions and strategies set in motion by ND hospitals include:

- Falls risk assessment on admission and ongoing
- Incorporation of falls risk and patient individualized prevention strategies in care plan
- Post fall huddles to help understand why the fall occurred and update prevention strategies
- Communication with patients and families that incorporates falls risk and teach backs

Strategies to Reduce Healthcare-acquired Infections

According the Healthy People 2020, it’s estimated that at any one time in the United States, 1 out of every 25 hospitalized patients are affected by a healthcare-acquired infection (HAI). HAIs are important causes of morbidity and mortality and a significant burden to our healthcare system. Hand hygiene is regarded as the single most effective means to prevent healthcare associate infections (HAIs). With this in mind, many hospitals have bolstered their hand hygiene programs to include a clear expectation to staff that hand hygiene will be performed as well as frequent monitoring and real-time feedback. Additionally, many ND HRET HIIN hospital teams:

- Have become antibiotic stewards by implementing and/or refining programs that address appropriateness, dose, route and duration of antibiotic therapy.
- Are cognizant that indwelling devices create an opportunity for an infection and deliberately seek alternatives and/or focus on removing the device when an indication for its use no longer exists.
- Know their data and acknowledge that one infection is too many!

Onward and Upward

Sustaining high performance is challenging and takes enormous dedication on all levels of the healthcare spectrum. Innovation will be key to successfully sustain the gains and drive further improvement. Moving forward, hospitals have been challenged to:

- Conduct readmission interviews to help their quality and clinical staff understand the patient and caregiver’s perspective on why the readmission occurred (i.e., communication, care coordination, and other logistical barriers in the days after a patient’s discharge).
- Spread antibiotic stewardship into their outpatient settings, including EDs, clinics, community and retail pharmacies, etc.
- Participate in individual hospital and/or small group UP Campaign coaching – the UP Campaign, developed by Cynosure Health Improvement Advisors, streamlines interventions making it possible to impact several HIIN measures at once.
On October 3, 2017, the North Dakota Hospital Association’s (NDHA) 83rd Annual Convention and Trade Show will kick off in Fargo at the Hilton Garden Inn.

Education offerings include breakout sessions for CEO’s, CFO’s, nurse executives, and human resource professionals; plus general sessions for all participants and specific sessions for the members of ND HFMA, and the ND Healthcare Risk Manager’s Society, ACHE and NDONE.

The Opening Keynote speaker this year is Joe Torrillo. Joe takes us on his journey as a NYFD firefighter during the 9/11 attacks. His session, Buried Alive with the Will to Survive, is scheduled for 11:00am – 12:00pm on Tuesday, October 3.

New this year is a combined effort with HSI Solutions / Intalere and their 2017 Update Conference scheduled October 2-3, 2017 in Fargo at the Hilton Garden Inn. HSI Solutions is a subsidiary of the North Dakota Hospital Association and the two events will be sharing speakers on Tuesday, October 3rd. For more information on the Update Conference, follow this link to download the brochure: http://hsisolutions.org/hsi-events/updateconvention/.

Questions? Contact Pam Cook at pcook@ndha.org or by calling 701-224-9732.

Staying invested in your goals

It’s how Troy Nelson became one of Barron’s “Top 1,200 Financial Advisors.”

And, it’s how Troy helps his clients work toward important financial goals.

Troy has been named No. 1 in North Dakota for the 6th year in a row.

Barron’s “Top 1,200 Financial Advisors,” Mar. 6, 2017. Barron’s Top 1,200 criteria based on assets under management, revenue produced for the firm, regulatory record, quality of practice, philanthropic work and more. The ranking is not indicative of the financial advisor’s future performance. Neither Edward Jones nor its financial advisors pay a fee to Barron’s in exchange for the ranking. Barron’s is a registered trademark of Dow Jones & Co. For more information on ranking methodology, go to www.barrons.com.

Edward Jones

Troy Nelson
Edward Jones Financial Advisor
1701 Burnt Boat Dr.
Bismarck, ND 58503
701-255-1196
troy.nelson@edwardjones.com

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Edward Jones Financial Advisor
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troy.nelson@edwardjones.com

Questions? Contact Pam Cook at pcook@ndha.org or by calling 701-224-9732.
On July 24, 2017, Chairman Pat Tiberi (R-OH), U.S. House Ways and Means, Health Subcommittee, announced the “Provider Statutory & Regulatory Relief Initiative” to provide relief from the Medicare regulations and mandates that impede innovation, drive up costs, and ultimately stand in the way of delivering better care for beneficiaries. The Committee asked doctors, nurses, clinicians, and other health care professionals to identify opportunities to reduce legislative and regulatory burdens on Medicare providers and improve the efficiency and quality of the Medicare program for seniors and individuals with disabilities.

The initiative is designed to identify where red tape and burdensome mandates are driving up costs in the Medicare program and how they could be eliminated. The initiative will have three stages:

1. Feedback from stakeholders to learn more about the policies that improve health care – and the policies that stand in the way;
2. Roundtables with stakeholders across the country to continue the conversations and identify solutions; and
3. Take Congressional action based on feedback from stakeholders.

In response to the first step, the North Dakota Hospital Association, with input from members, provided feedback regarding how Congress can deliver statutory relief from burdensome Medicare mandates established in law and how Congress can work with Health and Human Services to deliver regulatory relief through administrative action in the following areas of concern:

- 1.340B drug program
- 2.96-hour condition of participation requirement
- 3. Direct supervision of outpatient therapeutic services rule
- 4. Telehealth payment restrictions
- 5. Outpatient site-neutral payment rule
- 6. Meaningful use of electronic health records
- 7. MACRA Quality Payment Program (QPP)
- 8. Cost-sharing Reductions (CSR)
- 9. Medicare Outpatient Observation Notice (MOON)

A courtesy copy of NDHA’s response was also provided to Senators Hoeven and Heitkamp and Representative Cramer.

Please contact NDHA if you would like more information about the response provided to the Ways and Means Health Subcommittee for this initiative.
As you plan your supply chain strategy, the first step is always asking the right questions.

At the highest level, a sound supply chain strategy begins with defining needs and opportunities and then coming up with a game plan that allows for the ability to optimize the people, processes and technology within the organization to deliver greatest value.

Corporate strategy drives supply chain strategy. When your supply chain aligns with the corporate mission and vision and is championed by senior leadership, it becomes an integral part of your organization’s success.

Use our milestones map below to kick off your next supply chain strategy discussion.

1. **Define Your Needs**
   - Conduct a qualitative assessment of our people, processes and technology.
   - What is the current state of our supply chain structure?
   - Identify our customers, both internal and external.
   - What industry benchmarks are relevant to our facility?

2. **Define Your Opportunities**
   - How do we compare to the industry benchmarks identified in step 1? (gap analysis)
   - What processes must change or improve to achieve our strategy?
   - What technology or systems must change or improve to enable our strategy?

3. **Align with Corporate Vision and Mission**
   - How do we engage senior leadership to recognize and support supply chain as a critical component of corporate success?
   - How do we improve the understanding throughout the organization of the scope of the supply chain and its potential impact on profit?

4. **Hire and Empower Supply Chain Experts**
   - What additional skills will our strategy require of our supply chain organization?
   - What areas of the organization will supply chain need to effectively influence?

5. **Educate and Train Staff**
   - How can we better define roles and responsibilities?
   - What additional training will our staff need, e.g., lean, Six Sigma, new technology?

6. **Optimize People, Processes and Technology**
   - How can we improve metrics or key performance indicators (KPIs) to better gauge our operational performance?
   - How can we improve standard operating procedures for managing inventory across the supply chain?
   - How can we improve systems/technology platforms to better support our strategy?

7. **Continuously Improving Culture**
   - Which areas should we focus on in the next twelve months, to foster continuous, incremental improvements and success?
   - Which areas should we target for the long term?

A RECOMMENDED SIDE TRIP
In your search for the ideal supply chain, look beyond traditional industry solutions and study proven business strategies used outside of healthcare.

Learn More About Our Solutions!
Contact Kim Granfor at HSI Solutions
kgranfor@hsicoll.com or call 800-442-0462
NDHA Board of Directors

Keith Heuser, Board Chair
President
CHI Mercy Health
570 Chautauqua Boulevard
Valley City, ND 58072
(701) 845-6461
keithheuser@catholichealth.net
2nd Term thru 2018

Dan Kelly
CEO
McKenzie County Healthcare System
PO Box 548
Watford City, ND 58854
(701) 842-3000
dkelly@mchsnd.org
1st Term thru 2017

Tim Sayler
West Region COO
Essentia Health
1702 S. University
Fargo, ND 58103
(701) 364-3421
Timothy.sayler@essentiahealth.org
1st Term thru 2018

Andrew Lankowicz
President
CHI St. Alexius Health Devils Lake Hospital
1031 7th Street NE
Devils Lake, ND 58301
(701) 662-2131
andrewlankowicz@catholichealth.net
1st Term thru 2019

Darrol Bertsch, AHA RPB 6 Delegate
CEO
Sakakawea Medical Center
510 8th Ave NE
Hazen, ND 58545
(701) 748-7240
dbertsch@smcnd.org
Term thru Jan. 2016-Dec. 2019

Dr. Craig Lambrecht, Board Chair
Executive Vice President
Sanford Medical Center Bismarck
300 N 7th Street
Bismarck, ND 58506
(701) 323-6000
Craig.lambrecht@sanfordhealth.org
1st Term thru 2017

Jac McTaggart
Senior Director
Sanford Hillsboro Medical Center
12 Third Street SE
Hillsboro, ND 58045
(701) 636-3201
jac.mctaggart@sanfordhealth.org
2nd Term thru 2017

Reed Reyman
President
CHI St. Alexius Health Dickinson Medical Center
2500 Fairway Street
Dickinson, ND 58601
(701) 456-4390
reedreyman@catholichealth.net
Fulfill Term thru 2018

Alan O’Neil
CEO
Unity Medical Center
164 13th Street West
Grafton, ND 58237
(701) 352-9361
aoneil@unitymedcenter.com
1st Term thru 2019

Jerry E. Jurena, Board Secretary/Treasurer
President
ND Hospital Association
1622 E. Interstate Avenue
Bismarck, ND 58503
(701) 224-9732
jjurena@ndha.org

Andrew Lankowicz
President
CHI St. Alexius Health Devils Lake Hospital
1031 7th Street NE
Devils Lake, ND 58301
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andrewlankowicz@catholichealth.net
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Sakakawea Medical Center
510 8th Ave NE
Hazen, ND 58545
(701) 748-7240
dbertsch@smcnd.org
Term thru Jan. 2016-Dec. 2019

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Sanford Medical Center Bismarck
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Bismarck, ND 58506
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dbertsch@smcnd.org
Term thru Jan. 2016-Dec. 2019

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Executive Vice President
Sanford Medical Center Bismarck
300 N 7th Street
Bismarck, ND 58506
(701) 323-6000
Craig.lambrecht@sanfordhealth.org
1st Term thru 2017

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2nd Term thru 2017

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reedreyman@catholichealth.net
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President
ND Hospital Association
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Bismarck, ND 58503
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Sanford One Call services have not changed.