10 | Helping to Combat the Opioid Abuse Epidemic
By: Senator John Hoeven

11 | House Committee Considers Improvements to Medicare 340B Drug Pricing Program
By: Congressman Kevin Cramer
“Our community-owned health system has provided outstanding healthcare to our region for over 130 years. Now, we are launching the plan for the next 130 years. It is a commitment to our region’s physical and economic health for generations to come. It will also enable us to expand our efforts in population health and engaging with our residents throughout their lives to keep them well.”

Dave Molmen, CEO of Altru Health System

“This Bold New Era is going to result in exceptional facilities that will transform the way Altru Health System serves its patients, families, community, and staff. This is an exceptional opportunity to truly impact the delivery of healthcare in our community, and JLG Architects is so proud to be a part of it.”

Todd Medd, Principal Healthcare Leader at JLG Architects
Welcome to Insight

I hope everyone is finally getting to enjoy a little of the spring weather that is coming our way. Even as the weather is changing, our agenda seems to be the same: Medicaid expansion is still a major focus for us. It does not matter if you manage a tertiary hospital, a Critical Access Hospital, or a combination of health care delivery systems, if Medicaid Expansion is not keeping you awake at night, then the lack of a workforce should. An aging population and a shortage of health care workers have us all feeling the strain. It does not matter which positions you need to fill, there just does not seem to be enough talent available. And behavioral health and the opioid crisis have added significant challenges of their own to our health care system.

To top all of this off, the overall delivery of health care is being challenged. We will, in the not too distant future, be paid purely based on value. This is a big change for many of us who have spent our careers being paid on a fee-for-service basis. Volume has been the key. We will now have to learn how to manage on a set reimbursement amount and concentrate on reducing expenses. The ultimate key to success in this transition is for hospital leaders to understand their costs in detail and improve margins as much as possible by reducing every category of waste. This change, while intimidating, is also exciting because it is driving improvements in health care by mandating better care at a lower cost.

Another change will be accountability. In the past, we were responsible for what happened in our hospitals, but the consequences were not as significant as today. Going forward, there will be penalties for the provider, as well as those managing and governing hospitals, to explain and justify their conduct. Trustees will be held to account for failure in governance more than ever before as we change from a fee-based system to pay for performance. Hospital leaders must assure their stakeholders that they hold themselves to high standards and accept complete accountable for their performance to deliver high quality care at a lower cost.

Do you remember these acronyms: “HMO” and “PPO”? The health care acronym of the day is now “ACO”. We have witnessed a progression of changes to drive innovation in health care and it is not over. The speed of change will increase, as will the accountability. These transition-related challenges health care providers face may seem insurmountable, but they provide an opportunity for us to find inventive ways to integrate care and gain financial incentives for reducing cost while improving the quality of care. Insight is here to provide you with ideas that will challenge you and help you navigate these changes taking place in our health care world.

I hope you enjoy the magazine.

Jerry Jurena, President
ND Hospital Association
in recognition of a shortage of healthcare workers in North Dakota, shortly after being sworn into office, Governor Doug Burgum convened a taskforce composed of a diverse group of stakeholders to examine the issue, identify causes, possible solutions, and to make recommendations to address this critical shortage. With the support of the Governor’s office, the taskforce (or sub-committees thereof) is in the process of developing detailed recommendations, plans and timelines to achieve measurable outcomes to address North Dakota’s nursing shortage, liaising with the Workforce Development Council and Main Street Initiative team.

**Theme 1: Entry into Nursing Programs**

While interest in nursing programs in North Dakota is strong, other barriers to entry to North Dakota nursing programs require resolution to maximize nursing program capacity. This understanding will be critical to ensure that available seats are maximized. Strategies include:

- Develop and implement a standard nursing program application and coordinated application review/acceptance system (including application deadlines). Verify that there is a consistent pre-nursing curriculum across all programs and standardize pre-nursing curriculums.

- Finalize career pathway map (including CNAs) and develop distribution strategy for maximal impact.

- **Study** impact of prioritized acceptance of ND high school students into North Dakota nursing programs, including success and retention rates, student loans, etc.

- **Study** the impact of health science CTE classes on students entering nursing programs in ND

- **Study** attrition and graduation rates for nursing programs to determine whether our existing capacity is optimized.

**Theme 2: Expanding Program Capacity, Focusing in Rural Areas**

In 2015-16 there were 305 LPN seats, 663 RN seats, and 101 APRN seats across the fifteen ND programs (1069 seats total). Current projections indicate a shortage of nurses (LPN’s, RN’s, and APRN’s) that will continue for the next ten years due to many factors, including aging nurses, the aging population in general, and the increase in chronic disease that accompanies an aging population. Current estimates suggest the need for net new additions of more than 370 nurses per year for the next ten years (3,700 in ten years). This shortage is particularly acute in North Dakota’s most rural areas. Strategies include:

- Explore the impact and lost revenue to ND education programs of out-of-state utilization of ND clinical sites.

- Promote development of remote nursing education programs sites to address rural needs, including a comprehensive study to determine which programs possess this capability; cost; facility needs/benefits; framework for connecting programs with partners; etc.

- Promote development of additional rural clinical sites, including housing and community inclusion programs.
• Promote development of financing opportunities, tax incentives, loan re-payment programs (FACULTY).

• Develop a best practice model for a “dual role” practitioner/faculty member and pilot. Refine and implement “dual role” model.

**THEME 3: DEVELOP STRATEGIES TO RETAIN NORTH DAKOTA NURSING PROGRAM GRADUATES AND PRACTICING NURSES.**

In the past six years, more RN’s have transferred into the state than were produced through ND nursing programs – a positive trend that would be beneficial to continue. Further, data shows that ND-educated nurses tend to stay in North Dakota post-graduation for a time, but data also indicates an increase in the likelihood for a nurse to leave the state 2+ years after graduation, and that at 5-7 years post-graduation, the average retention rate is 48.68%. (Less than half of RN graduates that graduated in 2010-2012 are still employed in ND.) Finally, survey feedback indicates the need to improve workplace cultures to create a more engaging and safe working environment for nurses, for greater longevity and continuity. Strategies include:

• Address salary disparity through creating a mechanism to assist healthcare organizations in evaluating the return-on-investment that could be achieved when replacing the cost of traveling nurses with pay increases for local, permanent staff.

• Develop a chart or map to compare the clinical practice hours and required contract hours of ND in comparison with other states. Include obtaining, maintaining and reactivating a nursing license.

• Promote development tax incentives for employer/employee, and student loan repayment programs contingent upon ND retention for period of time.

• Develop a framework for organizations to assess and improve workplace culture, accompanied by a designation acknowledging the attainment of a best-practice nursing culture.

• **STUDY** the reason for post-graduation nurse exits to determine reasons for nurses departing the STATE (after graduation).
Theme 4: Develop strategy for in-migration of qualified nurses.

Even if nursing program capacity is increased and retention strategies are effective, there will still be a need to recruit qualified nurses to North Dakota to address the nursing shortage. The taskforce understands that the need to recruit talented professionals from out-of-state to address the workforce shortage is not unique to North Dakota, thus recommends a unified in-migration action plan that differentiates North Dakota from other states with regards to quality of life, and the nursing profession specifically.

For questions or more information contact Michelle Kommer, Labor Commissioner/Executive Director of Job Service ND at mkommer@nd.gov, or Patricia Moulton, Executive Director, ND Center for Nursing at patricia.moulton@ndcenterfornursing.org.
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Volume 3 • Issue 2 Spring 2018 • 7

Affecting Hospitals Today
A View from the Capitol

By John Flink

The story of this Congress can be told in two chapters – what happened between October 1 and March 23 and the rest of the year.

Following the September collapse of efforts to repeal and replace the Affordable Care Act (ACA) and radically restructure Medicaid, Congress turned to a host of unfinished budget issues.

In a series of continuing spending resolutions, budget bills, the omnibus FY 2018 appropriations bill and the Tax Cuts and Jobs Act of 2017, Congress raised the ceiling on federal spending, appropriated funds through September 30 and passed a sweeping tax bill. These measures also included a number of provisions affecting health care. Among these were:

• Funding for 10 years for the Children’s Health Insurance Program;

• A five-year extension of rural ambulance and home health payment add-ons;

• A two-year extension of funding for the National Health Service Corps, community health centers and the Teaching Health Center GME program;

• A two-year delay in the Medicaid disproportionate share hospital program payment cuts scheduled to begin in FY 2018;

• Preservation of the tax exemption for private activity bonds used by qualifying hospitals to meet their capital needs (included in the tax bill);

• A significant boost in funding for rural health programs at the Department of Health and Human Services;

• $3.6 billion to fight opioid abuse, including dedicating funds for workforce development programs that address the opioid epidemic;

• Funds to improve the nation’s broadband infrastructure, including $600 million for a Department of Agriculture pilot to expand broadband access in rural areas; and

• Significant increases in funding for federal low-income and senior housing programs.

There also were several developments affecting the ACA. The tax bill repealed the requirement that individuals obtain health insurance coverage beginning in 2019. It is unclear how this will affect enrollment next year.

The Trump administration significantly shortened the open enrollment period for those seeking health insurance coverage in 2018 and drastically reduced funding to help individuals sign up for coverage.

An effort to include funds for the cost-sharing reductions (CSR) authorized in the ACA and to establish reinsurance programs fell apart during the final negotiations of the omnibus appropriations bill. (CSRs help offset out-of-pocket expenses for low-income enrollees in the ACA’s individual insurance marketplace.)

Overall, the ACA continues to serve its purpose of ensuring health insurance coverage to uninsured Americans, despite Trump administration efforts to weaken the program. Enrollment in 2018 remains very close to 2017 levels, and after some rocky periods last year, the insurance market seems to be stabilizing.

What’s ahead? With the unfinished business out of the way, Congress has now turned its attention to the opioid epidemic. The Senate Health, Education, Labor and Pensions (HELP) Committee has held a hearing on a working draft of opioid legislation developed by its leadership and appears set to mark up its bill later this month.

The House Energy and Commerce Committee, on which Rep. Cramer serves, has held four days of hearings on more than 50 bills aimed at this crisis. A committee mark-up is expected later this month. Committee leaders say they want to have legislation voted on by the House before Memorial Day.

One key issue for us is to align 42 CFR, Part 2, which governs consent to release substance use disorder information about patients, with the privacy requirements in the Health Insurance Portability and Affordability Act.
Currently, it can be virtually impossible for clinicians to share necessary information.

Also on the horizon is congressional scrutiny of the 340B discount drug pricing program. Congress created this program to help those hospitals serving vulnerable communities expand access to prescription drugs and to support essential services in their community. The 340B program is vitally important in many North Dakota communities.

The program faces two threats. First, the Medicare outpatient prospective payment system 2018 rules impose a 28.5 percent cut on payments to certain 340B hospitals. The American Hospital Association is challenging this rule in court while legislation is also pending in Congress.

The second is even more real. For some time, the major drug companies have mounted a massive campaign to restrict the 340B program.

The House Energy and Commerce Committee – encouraged by this drug industry lobbying campaign – is especially eager to take on this program. Earlier this year, the committee released a report that summarizes its previous hearings and other material collected by the staff. (Elsewhere in this issue, Rep. Cramer provides a summary of the report and recommendations.)

One important finding for us is that “the 340B statute does not require covered entities to report program savings or how they are used. As a result, there is a lack of reliable data on how program savings are used, and covered entities may use these savings in a variety of ways.” This is a major issue for a number of committee members.

It is unclear what legislative recommendations the committee will try to advance or how the 340B process will play out in the House. The schedule will certainly work against efforts to pass major legislation, and, in an election year, forcing members to vote for the drug companies and against their hospitals could be politically dangerous.

In the Senate, the HELP Committee held a rather perfunctory 340B hearing just before Easter, but there is no indication the committee will take any further action.

Finally, the upcoming November election is now playing a crucial role in congressional and White House activity. Typically, in an election year, lawmakers are reluctant to take on controversial issues – that is likely to continue for the rest of this campaign cycle. Moreover, the turmoil in the White House has proved to be a major distraction for lawmakers.

In the House, Democrats need 23 seats to regain control, and many political commentators in Washington envision a scenario in which Democrats could win far more than that number in 2018.

The outlook for Democrats in the Senate is not so rosy. They have 26 seats up this year, including 10 in states that went for Trump in 2016 (e.g. North Dakota). Sen. Heitkamp’s bid for re-election is viewed as potentially one of the hottest races in the U.S. Meanwhile, Republicans have only two potentially vulnerable seats in play.

All-in-all, the second half of 2018 promises to be less hectic than the first 18 months of this Congress – but that doesn’t let North Dakota’s hospitals off the hook on federal advocacy. Even in slack times, there is plenty of work for us to do with our congressional delegation. We look forward to working with you in the months ahead.
Our nation is battling an opioid abuse epidemic. Too many individuals and families are struggling with substance use disorders, including in North Dakota where opioid overdose deaths tripled from 2013 to 2015. According to the Centers for Disease Control (CDC), drugs now kill more Americans – nearly 40 percent more – than car accidents. While our communities – from first responders and law enforcement officers to health care professionals and medical facilities – are on the front line of this public health emergency, we’re working at the federal level to provide state and local communities with additional resources and support to help combat opioid abuse.

Challenges associated with preventing and treating substance use disorders are only exacerbated in rural and frontier areas where access to health care services can already be limited due to distance and a shortage of health care providers. That is why I introduced bipartisan legislation that would direct the U.S. Department of Agriculture’s Rural Health and Safety Education Competitive Grants Program to give priority consideration to rural communities that will use funds to support substance abuse prevention, treatment and education initiatives.

In North Dakota, we have good examples of how ongoing rural initiatives can serve as helpful models for other parts of the country. Last year, I co-hosted a congressional briefing where CHI was able to share how they have worked collaboratively with stakeholders in small, rural communities in North Dakota and Minnesota to identify, prevent and treat behavioral health issues. Whether it be preventing prescription opioid diversion, using care coordination teams to address the individual needs of patients or increasing community education and awareness, efforts like these undertaken in our communities represent best practices that can be replicated in other parts of the nation that are experiencing similar challenges with mental health and substance use disorders.

At the same time, we’re also working to prevent illegal drugs from infiltrating our communities. Fentanyl is playing an increasing role in the number of opioid overdose-related deaths across the country. That’s why I introduced the bipartisan Illegal Synthetic Drug Safety Act, which would close an existing loophole that enables companies to circumvent the law and sell synthetic variations of drugs, like fentanyl, by labeling the products as “not for human consumption.”

Bad actors – including many laboratories which are based in China – have exploited this loophole to produce versions of synthetic drugs by altering the molecular structure slightly and then labeling the drugs for use in industrial and medical trials, and therefore not intended for human consumption. While these substances are technically different, they hold the same dangerous risks as the original drug. Passing our bill will be an important step forward in helping to keep these deadly drugs out of our communities.

Additionally, we’re working to prevent deadly drugs from entering the country through the mail system. I’m cosponsoring the Synthetic Trafficking and Overdose Prevention (STOP) Act, which would require shipments from foreign countries sent through the U.S. Postal Service to provide electronic data. This will enable Customs and Border Protection to better target potential illegal substances like fentanyl and prevent it from being shipped into the country.

We also continue to build on the work done through the Comprehensive Addiction and Recovery Act (CARA) and the 21st Century Cures Act, which provided resources and expanded prevention, treatment, law enforcement, and recovery programs to help combat the substance abuse epidemic. Congress also provided $4 billion to fight the opioid abuse epidemic in the Fiscal Year 2018 funding legislation – to help ensure that communities have resources for prevention, treatment and law enforcement activities.

We appreciate the efforts of health care providers to prevent drug abuse and treat those suffering from addictions. Combating the opioid abuse epidemic is no small task, but by continuing to work together, we can fight back, end the epidemic and save lives.
In January, the House Energy and Commerce Committee, of which I am a member, released an oversight report on the Medicare 340B Drug Pricing Program. This report was based on information Committee Members and staff gathered over two years of examining the program’s operation and oversight through stakeholder meetings, document requests and during Committee hearings held last fall.

I have been a longtime supporter of the 340B Program, primarily because of the benefit it brings to North Dakota’s rural hospitals. Since it was created in 1992, the drug discounts hospitals and other health care providers have received from drug manufacturers have made a significant contribution to the quality of their patient care.

Through this extensive review process, the Committee noted the program’s strong bipartisan support, while identifying weaknesses in the program’s administration and oversight. It also highlighted areas of improvement and reform.

Among the report’s findings are:

- Congress did not clearly identify the intent of the program, nor its parameters.
- The Health Resources and Services Administration (HRSA) that administers the program in the Department of Health and Human Services, lacks sufficient regulatory authority to adequately oversee the program and clarify requirements.
- HRSA has started but still has not completed the process to issue and enforce regulations in the areas in which it has regulatory authority.
- Although HRSA has increased the number of covered entity audits it conducts each year, the audit process still needs improvement.
- The 340B statute does not require covered entities to report program savings or how they are used. As a result, there is a lack of reliable data on how program savings are used, and covered entities may use these savings in a variety of ways.

To help address these and other concerning findings, the report makes 12 recommendations, including:

- HRSA should finalize and begin enforcing regulations in the three areas in which it currently has regulatory authority.
  1. Establishing and implementing a binding Administrative Dispute Resolution process for the resolution of certain disputes relating to compliance with 340B program requirements.
  2. Providing for the imposition of civil monetary penalties against manufacturers that knowingly and intentionally overcharge a covered entity for a 340B drug.
- Issuing precisely defined standards of methodology for calculation of 340B ceiling prices.
- Congress should give HRSA sufficient regulatory authority and resources to adequately administer and oversee the 340B program.
- Congress should clarify the intent of the 340B program to ensure that HRSA administers and oversees the 340B program in a way that is consistent with that intent.
- Congress, or HRSA where HRSA already has authority to make such changes, should promote transparency in the 340B program, including ensuring that covered entities and other relevant stakeholders have access to ceiling prices, and requiring covered entities to disclose information about annual 340B program savings and/or revenue.
- Congress should establish a mechanism to monitor the level of charity care provided by covered entities.

The Energy and Commerce Committee has primary jurisdiction over healthcare policy in the House of Representatives, and I look forward to working with the Administration and fellow Members of Congress to improve this program’s oversight and implement reforms. As always, I welcome your input on these findings and how we can move forward to preserve the 340B Program to better serve our rural hospitals and the thousands of North Dakotans who benefit from it.
In 2017, the ND Hospital Association (NDHA) and HSI Solutions (HSI) teamed up and held the NDHA Annual Convention and the HSI Update 2017 Conference in a cross-over event allowing us to share speakers.

This year, we are excited to again offer the cross-over event! The event is scheduled for October 9-11, 2018 at the Double Tree by Hilton in West Fargo, ND. NDHA and HSI will each have their own educational tracks specific to their own audiences. By collaborating, we will again be able to share keynote and general session speakers. Other groups that will be represented and have educational offerings include the ND Healthcare & Finance Management Association (NDHFMA), the ND Society of Healthcare Risk Managers (NDSHRM), and the ND Organization of Nurse Executive (NDONE). To make things more cost and time effective, the vendor show will be combined into one great show! Not only will vendors gain additional exposure to both Update and NDHA convention participants, but the participants will also gain a wider variety and increased number of vendors.

The trade show is scheduled for Wednesday, October 10th from 10:30am – 1:30pm. The vendor registration link is posted on each website: www.ndha.org and www.hsisolutions.org. Keep an eye out in early June for the participant brochure with event details.
A recent federal Medicaid payment policy shift presents a unique opportunity for state Medicaid programs serving American Indian populations to access more federal dollars for health care.

The Centers for Medicare & Medicaid Services (CMS) new policy allows for 100 percent federal payments when an American Indian (AI) Medicaid beneficiary receives care outside an IHS/Tribal facility, so long as the referring and receiving facilities have in place a Care Coordination Agreement. The shift reflects an effort to help states, IHS, and Tribes improve access to care, strengthen continuity of care, and address disparities in health care outcomes.

Currently, Medicaid payments at non-IHS/Tribal facilities for Medicaid-eligible AIs are subject to states’ regular Federal Medicaid Assistance Percentage, or FMAP, costing states millions of dollars. North Dakota’s current FMAP is 50 percent, meaning that for every one dollar spent on medical services, the federal government contributes fifty cents.

In North Dakota, there are approximately 24,500 American Indians eligible for Medicaid. While the likely savings is difficult to measure, hospital leaders estimate that it has the potential to save millions of dollars annually once implemented across the state.

North Dakota hospitals are stepping up to establish CCAs to help preserve Medicaid Expansion reimbursement rates. During the 2017 legislative session, North Dakota hospitals leveraged CCA participation in exchange for sustained Medicaid Expansion reimbursement rates—a proposition that will result in better access to health care and improved care coordination for the patients served by both IHS/Tribal health care and non IHS health care providers.

To launch the initiative, N.D. Department of Human Services is rolling out a pilot project with Standing Rock IHS in Fort Yates. Stakeholders include Tribal health care providers, Standing Rock IHS, N.D. Indian Affairs Commission, Great Plains IHS, N.D. Medical Association, CHI St. Alexius and Sanford Health Bismarck and NDHA. The group began meeting in June 2017 to discuss care coordination and workflows necessary to capture the enhanced federal funding. CCAs were signed in February and both hospitals are now tracking applicable referrals and reporting them to NDDHS via the Medicaid billing process.

The “savings” returned to North Dakota are to be deposited in the N.D. Health Care Trust Fund.

“In addition to improving coordination efforts and increasing access to care, this initiative is an important step towards finding solutions to ensure sustainability of our state’s Medicaid program,” said Jerry Jurena, NDHA President. “Medicaid Expansion reimbursement rates are the reason many of our critical access hospitals are able to keep their doors open. Working together with state and tribal leaders to support this critical program is a top priority for North Dakota hospitals.”

The stakeholder group will next discuss rolling this project out to other IHS and Tribal facilities in the state and to additional non-IHS health care providers.

**What is a Care Coordination Agreement?**

Per CMS guidelines, a Care Coordination Agreement must include the following elements to secure 100 percent federal payments for services provided outside an IHS facility:

- **Referral** – The IHS/Tribal facility practitioner provides a request for specific services to the non-IHS/Tribal provider
- **Information Sharing** – The non-IHS/ Tribal provider sends information about the patient care provided, including test results and treatment, to the IHS/Tribal facility practitioner
- **IHS Assessment** – The IHS/Tribal facility practitioner continues to assume responsibility for the patient’s care by assessing the information received and taking appropriate action
- **Updated IHS Medical Record** – The IHS/Tribal facility incorporates the patient’s information in the patient’s medical record
We have all heard about the opioid crisis and the impact it is having on our family, friends, businesses and communities. Overdose deaths in North Dakota increased from 20 deaths in 2013 to 77 deaths in 2016 (CDC/NCHS, National Vital Statistics System, Mortality). To effectively address this crisis, a multifaceted approach is necessary. This approach must include primary prevention of opioid use disorders, secondary prevention of overdose deaths, and effective treatment and recovery services supporting individuals with an opioid use disorder.

North Dakota initiated action prior to the nationwide epidemic coming to be, including the development of the Prescription Drug Monitoring Program in 2005, the Take Back programs starting in law enforcement centers in 2009 and in 2013 the ND Department of Human Services was approved as the Opioid Authority to initiate Opioid Treatment Programs in the state.

With the gaining national attention and funding resources, North Dakota has continued making strides in addressing the opioid crisis in recent years. In 2017, the ND Department of Human Services was awarded a one-year two million dollar grant (State Targeted Response to the Opioid Crisis Grant [Opioid STR]) to increase evidence-based treatment and recovery services for individuals with an Opioid Use Disorder and increase implementation of evidence-based primary and secondary prevention strategies.

**EFFORTS TO INCREASE PREVENTION**

- Communities are increasing the number of Take Back locations and promoting the availability of these locations to the general public.
- Governor Doug Burgum signed an Executive Order 2017-16 directing agencies to make naloxone readily available.
- Through the additional federal grant funds, the ND Department of Human Services has purchased and is distributing approximately 4,000 kits and funded an additional over 900 kits distributed by community partners. Individuals who have received these kits include: general public, law enforcement, game and fish, social services, care coordinators, peer support specialists, sober/recovery living homes, domestic violence shelters, substance use disorder treatment centers, recovery organizations, public health, tribes, community health organizations, family members, and individuals at risk.
- North Dakota communities have provided over 150 trainings on effective overdose prevention to approximately 3,000 nurses, first responders, general public, corrections, behavioral health providers, educators and administration.
- Over three hundred individuals have been trained in prescribing guidelines through the additional federal funding supporting community efforts.
- Approximately four hundred individuals were able to access medication-assisted treatment because of additional funding support provided through communities.
- During the 2017 legislative session, funding was added to the Substance Use Disorder Voucher program to cover methadone for individuals who are eligible. Since then, more than 570 individuals have received SUD Voucher covered services for methadone maintenance.
- Prior to August 2016 no Opioid Treatment Programs (OTPs) or methadone services were available in North Dakota. Within eighteen months, North Dakota now has three OTPs with over five hundred admissions.
- Peer support specialists have been trained to provide recovery support services in North Dakota.
- The number of providers waivered to prescribe buprenorphine as increase from eighteen to forty in twelve months.

Although much has been accomplished in the state, continued work is vital – especially to increase access to medication-assisted treatment, evidence-based recovery and overdose prevention services. The ND Department of Human Services received a second year of the Opioid STR grant and continues to work with state-level and community providers to effectively prevent, treat and provide ongoing support to the individuals in North Dakota.

To find more information and resources on efforts, visit [www.behavioralhealth.dhs.nd.gov/addiction/opioid](http://www.behavioralhealth.dhs.nd.gov/addiction/opioid).
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Finding confirm that hospital financial executives are facing increasingly challenging revenue cycle management and worsening payment:

- Some health insurers are making it more difficult for hospitals and health systems to collect revenue—52.2 days for the lowest AR and 67.7 days for the highest.
- Initial denial rates among those five national payers varied from 7.5 percent to 11.1 percent of net patient service revenue (NPSR); one of every 10 dollars of revenue is at risk for nonpayment.
- Uncollectible claims ranged from 0.8 percent to 2.4 percent of NPSR.
- The payer with the highest denial rate used the request for additional medical information description more than three times as often as the payer with the lowest rate.

The disparity in denial activity—with similar claims denied dissimilarly—puts hospitals at a disadvantage. A disconnect between hospital managed care contracting and revenue and billing cycle departments over what is actually collectible exacerbates the problem.

Darker Days Ahead

In a 2018 “Healthcare Outlook,” Navigant predicted an uptick in uncompensated care after years of decline as a result of potential cuts to the Affordable Care Act (ACA), growing reliance on high deductible insurance plans, and a rise in uninsured populations. A November Moody’s Investors Service report found that bad debt increased in 2017 after a decline from 2014-16 and predicted that bad debt will grow 6-7 percent in 2018, partly attributable to rising copayments and increased patient reliance on high deductible health plans.

It’s no wonder that a Navigant/HFMA survey of 125 hospital and health system CFOs found that 90 percent are concerned about consumer self-pay and less than half have established revenue integrity programs. Navigant Managing Director Jake Morris’ advice to hospitals:

- Tighten revenue cycle functions.
- Implement strategies for rating credit quality to target collection efforts where they’re likely to yield results.
- Develop manageable payment plans for households with less income.

Clear Clouds of Uncertainty

Here are some suggestions for hospitals plagued by denials, especially in areas of eligibility, medical necessity (particularly for outpatients), level of care assignment, and notifications.

- Use software that reveals eligibility and co-payments to help staff educate patients about charges for services and what they will be billed.
- Establish policies and procedures around Emergency Department leveling.
- Focus on point-of-service collections and clearly communicating out-of-pocket costs to combat health insurance illiteracy.
- Work closely with payers to reduce denial rates to avoid:
  - Unhappy patients getting caught in the middle, receiving unexpected bills
  - Dissatisfied health plan members
- Combine business office and medical records department to create an RCM team.
- Incentivize staff for each upfront payment collected.

There will always be challenges associated with revenue cycle management. However, finding solutions that will help your team work quickly and efficiently is the key to weathering the storm.
Assistive Technology can be the key to staying out of a skilled nursing facility for people who are aging and/or have disabilities, potentially saving millions in Medicaid and Medicare costs. With the 2018 average yearly cost of a nursing home stay in ND at over $97,000 a year, we should be looking at ALL avenues that prevent a nursing home stay and allow people to stay safely and independently in the home of their choice, which in most cases is NOT a nursing home. In fact according to a 2014 AARP study, 87% of seniors age 65+ indicated they wanted to stay in their current home and community.

Assistive technology (AT) devices such as no-monthly-fee alerting systems, grab bars, daily living aids, ramps, smart home technology, and locked medication dispensers are just some of the devices that can help prevent a nursing home stay. At ASSISTIVE, North Dakota’s state AT program, we help connect people with technology of this type every day.

In 2007, a rural ND family connected with ASSISTIVE to help their mother stay in her home after a hospitalization due to medication mismanagement. The ASSISTIVE staff evaluated her needs and recommended a locked medication dispenser. The device was purchased and a nursing home placement was avoided. We recently heard that she was still living in her home nearly 10 years later, all because of this $150 locked medication dispenser.

With the total cost of nursing home care in North Dakota for one person for 10 years of approximately $766,716 (based on info from the ND Department of Human Services) and the cost of the locked dispenser at $150, this is an incredible ROI (return on investment) of approximately $766,566! Money well spent and independence that is priceless!

ASSISTIVE consultants are available to assess individual needs and recommend AT solutions. We offer a short-term AT equipment loan program, so people can try before they buy. We also provide assistance with finding funding to get the AT devices in the hands of the people who need them. We have two Home First Demonstration Centers in Mandan and Fargo (simulated homes filled with assistive technology in every room) where we provide equipment demonstrations, education, and hands-on access to AT to help North Dakotans understand how AT can help them stay in their homes longer as they age versus having to move to a more restrictive environment. If you would like assistance, please contact ASSISTIVE at info@ndassistive.org or 1.800.895.4728.
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</tr>
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<td>Pat Branco</td>
<td>CEO</td>
<td>Heart of American Medical Center 800 S. Main Avenue Rugby, ND 58287-0399 (701) 776-2218 <a href="mailto:pbranco@hamc.com">pbranco@hamc.com</a> Fulfill Term thru 2019</td>
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<tr>
<td>Dr. Craig Lambrecht</td>
<td>Executive Vice President</td>
<td>Sanford Medical Center Bismarck 300 N 7th Street Bismarck, ND 58506 (701) 323-6000 <a href="mailto:craig.lambrecht@sanfordhealth.org">craig.lambrecht@sanfordhealth.org</a> 2nd Term thru 2020</td>
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<td>CHI St. Alexius Health Devils Lake Hospital 1031 7th Street NE Devils Lake, ND 58301 (701) 662-2131 <a href="mailto:andrewlankowicz@catholichealth.net">andrewlankowicz@catholichealth.net</a> 1st Term thru 2019</td>
</tr>
<tr>
<td>Jeff Herman</td>
<td>CEO</td>
<td>Prairie St. Johns 510 4th Street South Fargo, ND 58103 (701) 476-7270 <a href="mailto:jeff.herman@uhsinc.com">jeff.herman@uhsinc.com</a> 1st Term thru 2020</td>
</tr>
<tr>
<td>Darold Bertsch</td>
<td>Delegate</td>
<td>Sakakawea Medical Center 510 8th Ave NE Hazen, ND 58545 (701) 748-7240 <a href="mailto:dbertsch@mcnd.org">dbertsch@mcnd.org</a> Term thru Jan.2016- Dec. 2019</td>
</tr>
<tr>
<td>Reed Reyman</td>
<td>President</td>
<td>CHI St. Alexius Health Dickinson Medical Center 2500 Fairway Street Dickinson, ND 58601 (701) 456-4390 <a href="mailto:reedreyman@catholichealth.net">reedreyman@catholichealth.net</a> Fulfill Term thru 2018</td>
</tr>
<tr>
<td>Alan O’Neil</td>
<td>CEO</td>
<td>Unity Medical Center 164 13th Street West Grafton, ND 58237 (701) 352-9361 <a href="mailto:aoneil@unitymedcenter.com">aoneil@unitymedcenter.com</a> 1st Term thru 2019</td>
</tr>
<tr>
<td>Dan Kelly</td>
<td>CEO</td>
<td>McKenzie County Healthcare System PO Box 548 Watford City, ND 58854 (701) 842-3000 <a href="mailto:dkelley@mcndnd.org">dkelley@mcndnd.org</a> 2nd Term thru 2020</td>
</tr>
<tr>
<td>Jerry E. Jurena</td>
<td>Board Secretary/Treasurer</td>
<td>ND Hospital Association 1622 E. Interstate Avenue Bismarck, ND 58503 (701) 224-9732 <a href="mailto:jjurena@ndha.org">jjurena@ndha.org</a></td>
</tr>
<tr>
<td>Nate White</td>
<td>Executive Vice President</td>
<td>Sanford Medical Center 801 Broadway North Fargo, ND 58122 (701) 234-6850 <a href="mailto:nate.white@sanfordhealth.org">nate.white@sanfordhealth.org</a> Fulfill Term thru 2018</td>
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