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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: pcook@ndha.org
The deadline for the Spring Issue is April 3rd, 2019.

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Welcome to Insight

Welcome to the Fall 2018 edition of Insight. As the new NDHA President, I look forward to collaborating with all of you as we look towards the future of healthcare. I would like to thank Jerry Jurena for his leadership for the past nine years. He will retire at the end of the year after more than four decades in the health care field, with nine of those years as NDHA President. He has done a great job leading the membership through some challenging times. If you get a chance to thank Jerry, please do so.

Although we deal with changes in health care daily, such as cuts in Medicare reimbursement, increased regulatory burdens, and the difficulty of the uninsured, much of our advocacy agenda seems to be the same. Medicaid reimbursement, Medicaid Expansion, workforce, and behavioral health are the top issues facing our hospitals. I hope you will take a few moments to read the article on our state legislative priorities for 2019. It will take all of us working together to explain our concerns to legislators and ensure they understand the fundamental role hospitals and health systems play in the health of North Dakota communities.

Medicaid Expansion will end August 1, 2019, unless reauthorized by our state legislature. The importance of this program cannot be overstated. Bad debt and charity care were greatly reduced when Medicaid Expansion was authorized in North Dakota. It has provided previously uninsured patients with health care they otherwise would not have sought and made many of our hospitals viable again. In short, Medicaid Expansion is good for the health of our patients and the economic climate of the communities we serve. Federal Medicaid dollars flow directly into local economies, supporting wages, employment, consumer spending, and state tax revenue. It has a $633 million impact this biennium on North Dakota’s healthcare infrastructure alone. But, the legislature will need to reauthorize it and appropriate additional funds (federal coverage dropped to 95 percent in 2017 and will drop to 90 percent in 2020).

To help us tell our story about how vital Medicaid Expansion is to us, our Foundation has engaged NDSU to study the economic effect of the program in North Dakota. We know that, in addition to improved health care outcomes for the previously uninsured, Medicaid Expansion has substantial economic effects because of increased spending on health care. Since the state has expanded coverage, the percentage of uninsured has declined and the number of people enrolled in Medicaid has increased by about 22,000. The expanded coverage means millions of federal dollars have been spent on health care coverage. However, as the state’s share for expanded Medicaid increases, policymakers and health care providers are interested in the economic and fiscal benefits and costs associated with continued participation in Medicaid Expansion.

While data suggest positive economic effects associated with the expansion of Medicaid, as well as reductions in uncompensated care costs for health care providers, the economic impact of Medicaid Expansion has not been documented for North Dakota. The study of the fiscal effect will greatly improve an understanding of the program’s impact on the state and serve to provide policymakers and health care providers a solid foundation on which to evaluate the state’s continued participation in the program. This information on program participation would be of most value if completed prior to the 2019 ND Legislative session.

The study will report the change in enrollment and spending since Medicaid Expansion’s inception using enrollment and expenditure data from the Centers for Medicare and Medicaid Services. Data from the Centers of Disease Control Behavioral Risk Factor Surveillance System will also be used to model changes in individual health behavioral data. It will consider the degree to which increases in spending represent spending on health care services that would not have occurred in the absence of Medicaid Expansion.

Evaluation of changes in statewide economic output will also be studied, including direct and indirect employment effects such as workers added by health care providers and employment accruing to the general economy necessary to support expanded output in health care industry, contribution to the gross state product, labor income, which represents wages and salaries of employment related to direct, indirect, and induced employment. Additional revenues accruing to state and local governments such as sales and use, personal income, corporate income, and miscellaneous revenues, such as licenses, fees, permits, fines, and other tax revenues (e.g., fuel, property).

I am very excited about how this study will help us tell our story about the importance of Medicaid Expansion to patients and hospitals. We will have other challenges to address as well during the upcoming legislative session and I look forward to seeing you at the State Capitol this winter. I hope you find that this edition of Insight provides you with information and ideas that will help you navigate these challenges in our health care world.

Enjoy the magazine.

Tim Blasl, President
ND Hospital Association
Please understand that the way this measure is written, **DEVOID OF RULES AND REGULATIONS** – which is what we will be voting on – if the measure passes:

- **Marijuana could be grown anywhere, by anyone over 21** – as much as they want, where ever they want to grow it.

- **Marijuana could be sold anywhere by anyone over 21 in any amount.** No regulations. No restrictions. Next to a school or church, at a public event, anywhere!

- **Any one person over 21 would be able to possess** as much marijuana as they want.

- **There would be NO rules or regulations,** NO quality testing requirements, NO special licensing.

- **NO special tax is written in the measure,** so there would be no "Big Money" for the state as many people assume.

- **Driving while impaired by marijuana would NOT be illegal**

- **There’s much, much more to know!!!!**

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Paid for by North Dakotans Against the Legalization of Recreational Marijuana, Bob Wefald, Chair
MEDICAID REIMBURSEMENT

* Overview
North Dakota Medicaid hospital reimbursement has not had an inflationary increase since 2015. Due to lower than predicted state revenue, the Governor ordered all State agencies in February 2016 to reduce their 2015-2017 budgets by 4.5%. This resulted in a 33% cut to Medicaid professional fee reimbursement – a reduction of $30.5 million for the remainder of the biennium. It also resulted in elimination of the budgeted 3% inflationary increase in the second year of the biennium, which represented an additional $6.5 million cut to hospitals.

Unlike other programs, state spending on Medicaid brings in federal revenue due to its financing structure. For every $1 cut in reimbursement, North Dakota loses an additional $1 in federal funds.

* Position
Adequate provider payment rates help to ensure equal access to necessary medical services for the children and adults who rely on Medicaid to get their health care. When Medicaid doesn’t cover the cost of delivering care, hospitals absorb the costs in the form of bad debt and charity care. These losses inevitably translate into a cost-shift to the private sector which drives up health insurance costs and negatively impacts hospitals’ ability to react to public health needs and invest in community services.

* Action Needed
Restoring funds eliminated from the Medicaid program in 2016 will ensure that providers have the resources they need to remain sustainable, but also to offset losses that have already been imposed. Investing more state dollars in the Medicaid program is the single most effective action North Dakota can take to increase overall health care funding and positively impact insurance costs for families and small businesses. The Legislature must commit to restore funds eliminated from the Medicaid program in 2016 and ensure that healthcare providers are afforded an annual inflationary increase.

MEDICAID EXPANSION

* Overview
Medicaid Expansion was authorized by the North Dakota legislature in 2013 and, unless reauthorized, will expire on July 31, 2019. This expansion fills historical gaps in Medicaid eligibility for low-income adults and currently covers 22,600 North Dakotans. If Medicaid Expansion is not reauthorized, childless adults would be ineligible for Medicaid. These individuals do not earn enough to qualify for premium tax credits to purchase Marketplace coverage through the health insurance exchange, so most of them are likely to remain, or will become, uninsured as they have limited access to employer coverage and are likely to find the cost of unsubsidized Marketplace coverage prohibitively expensive.

Medicaid Expansion was designed to significantly reduce the number of uninsured and improve their health by providing access to routine health care and preventive screenings. Medicaid Expansion has been very good for not only patients, but North Dakota communities and health care providers as well. Hospitals have seen a significant decrease in the amount of uncompensated care since the legislature’s 2013 authorization of Medicaid Expansion. Bad debt and charity care rose from $102 million in 2008 to $274 million in 2014—a nearly threefold increase. Thanks to Medicaid Expansion, which went into effect January 1, 2014, bad debt dropped nearly in half to $150 million in 2016.

Medicaid Expansion will bring in roughly $90 in federal matching funds for every $10 of state general funds invested in the program. Federal Medicaid dollars flow directly into local economies, supporting wages, employment, consumer spending, and state tax revenue. The budgeted amount for the 2017-2019 biennium was $633 million, which represents a huge impact on North Dakota’s healthcare infrastructure alone.

* Position
NDHA supports legislation to reauthorize the Medicaid Expansion program.

* Action Needed
The Legislature should reauthorize Medicaid Expansion and continue to implement the program through a private insurance carrier as it has since the inception of the program.
MEDICAID MANAGED CARE

* OVERVIEW

NDHA is supportive of truly innovative transformation within the Medicaid program that seeks to improve quality, lower cost, expand access to health care services for North Dakota’s Medicaid population, and preserve adequate payment to providers for those services.

States have planned and implemented managed care programs differently and results vary. However, evidence points to well-designed managed care as a solid strategy to promote quality patient care and control costs. Providers would like to work with the State to implement an innovative Medicaid managed care approach that uniquely serves the needs of North Dakotans. It will require a design that is inclusive; one that recognizes the varying ability of hospitals to bear risk, the need to protect our most vulnerable communities including our Critical Access Hospitals, and the need to work across organizational barriers.

* POSITION

NDHA supports a collaboration between the State and hospitals to design a Medicaid managed care program that will create incentives that encourage enrollees to take personal responsibility for their health, offer administrative simplification, program cost certainty, and in-depth data, and support practice innovations that further the objectives of efficient, patient-centered care delivery, and lead to improved health outcomes.

* ACTION NEEDED

The Legislature should consider a partnership model between the State and provider organizations to implement a Medicaid managed care system that contains costs and facilitates better coordination of care and better health outcomes for Medicaid recipients.

WORKFORCE – NURSING AND TECH JOBS

* OVERVIEW

Workforce challenges threaten access to health care services and the quality of care. With approximately 1,000 unfilled nursing positions, North Dakota health care providers are forced to hire expensive, temporary staff or limit access to critically-needed services. Hospitals unable to recruit and retain core staff increasingly are forced to divert patients out of town or even out of state.

Reimbursement rates must be fair in order for hospitals to compete in the workforce market today. Healthcare operates on a fixed reimbursement system, meaning providers cannot increase charges to offset increasing labor costs.

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Reimbursement rates must be equitable to the cost of care in order for healthcare providers to pay the salaries necessary to recruit and retain staff.

**POSITION**

NDHA supports legislation to implement fair reimbursement rates, interstate licensure compacts for health care professionals, and increasing slots in nursing and other healthcare education programs.

**ACTION NEEDED**

NDHA encourages the Legislature to adopt the Interstate Medical Licensure Compact; invest in programs to increase faculty for training healthcare professionals, allow seamless transitions between undergraduate degree programs, and provide incentives for providers to participate in clinical training of students; and provide adequate Medicaid reimbursement to ensure that hospitals are able to compete for physicians, nurses, and other healthcare professionals in the workforce market today.

**PHYSICIAN LICENSURE COMPACT**

**OVERVIEW**

Professional licensure compacts create an expedited licensing process for healthcare providers so they may practice in multiple states. The Interstate Medical Licensure Compact, which has been adopted in 18 states including Minnesota, Montana and South Dakota, is national model legislation that streamlines the licensing process in multiple states for physicians. The compact continues the requirement for physicians to be licensed in the state where the patient receives care. The compact creates another pathway for licensure, but does not otherwise change a state’s existing Medical Practice Act.

The benefit is substantial in a rural state such as North Dakota with multiple border communities. Recruitment of physicians takes place in an increasingly national market and has been made more difficult in our state because of high workforce demands and a growing population. In addition, the continued development of telemedicine services makes such legislation important as providers work to meet increased demand for services and provide better access to services closer to home through such new technologies.

**POSITION**

NDHA supports adoption of the Interstate Medical Licensure Compact as a means of assisting with physician recruitment,
promoting telehealth services, and better managing health care services in markets that cross state lines.

**Action Needed**
The Legislature should pass legislation to join the compact to provide an expedited licensure process for physicians seeking licensure in multiple states.

### Behavioral Health/Substance Use Disorder

**Overview**
An estimated 91,912 adult North Dakotans experienced some form of mental illness and 51,950 had a substance use disorder in the past year. North Dakota’s behavioral health system has critical gaps including a lack of early identification and intervention services, difficulty in accessing services, a lack of consistent screenings for at-risk populations, and a lack of, or barriers to, accessing community-based recovery supports. Prevention efforts alone can yield $10 of savings in health costs, educational costs, criminal justice costs, and lost productivity for every $1 invested.

Further compounding the problem, North Dakota does not have enough providers to address the growing need for behavioral health care. And the providers we do have are not evenly distributed across the state. Hospitals, jails, and prisons are becoming the safety net for patients with nowhere to go. Patients often seek care in emergency rooms as a last resort, which are overloaded and not equipped to provide sufficient care for these patients in this setting. If a patient is ultimately admitted to an inpatient psychiatric unit, there are limited resources available to assist in transitioning back to the community.

Good mental health is good for the community. Businesses benefit when employees have good mental health, which is associated with higher productivity, better performance, more consistent work attendance, and fewer workplace accidents. It is also good for families because good mental health supports our ability to have healthy relationships, maintain physical health and well-being, and make good life choices, which also reduce the burden on law enforcement and our judicial system.

**Position**
NDHA supports legislation to increase access to early prevention and intervention services as well as expanded treatment and recovery programs.

**Action Needed**
The Legislature must make behavioral health delivery reform and finance a top priority.

---

**State Concerns NDHA Will Monitor**

- **Medicaid IHS 100% FMAP project.** This project was started after the last session to improve the care coordination of, and federal reimbursement for, healthcare services provided to American Indians at non-IHS facilities so the State is reimbursed for 100% of payments made. These additional federal dollars will mean there is less burden on the State general fund for Medicaid.

- **AARP–Caregiver bill.** AARP has lobbied multiple times in North Dakota and other states for passage of the CARE Act, which would require hospitals to train lay caregivers for all after-care tasks required for a patient being discharged to home. NDHA continues to oppose this one-size-fits-all mandate because hospitals are already required to comply with discharge planning requirements of the Medicare Conditions of Participation (COPs).

- **Air Ambulance.** NDHA will monitor bills that may be introduced regarding air ambulance providers. A bill was passed last session to alleviate large bills that patients receive from out-of-network providers. Since then, there have been additional complaints about very large bills being imposed on patients by out of network providers, so the issue may come up again in the legislature.

- **Marijuana–Medical and Recreational.** The legislature may make revisions to the current medical marijuana law and legalization of recreational marijuana is on the November ballot. NDHA will monitor the initiated measure and any bills relating to marijuana.

- **Certificate of Need (CON).** NDHA will monitor any attempts to reinstate a certificate of need process in hospital licensing.

- **Construction Project Reviews and Fees.** The cost and time delay associated with review of hospital construction projects by the North Dakota Department of Health is a concern. NDHA will monitor efforts to make the process more efficient and less costly.

- **Pharmacy Benefit Managers (PBM).** NDHA will continue to monitor any bills that may be introduced relating to PBMs, especially the drugs that may be designated by a PBM or third-party payer as a specialty drug or a specialty pharmacy.

- **Telehealth.** In the 2017 session, the Legislature passed a bill requiring health insurers to provide coverage of health services delivered by means of telehealth and NDHA has since worked with North Dakota Medicaid to update its telehealth policies. NDHA will continue to support consistent payment structures across payers that will foster telehealth services to help patients who would otherwise lack adequate access to providers or services.
As I reflect on my role as the Chairman of the Board for the American Heart Association over the last couple years, there are several impactful accomplishments of which I am very proud. As a native North Dakotan, I am also incredibly proud that my home state has made significant investments in the health of all North Dakotans by establishing strong cardiac and stroke systems of care in the state—helping to ensure that no matter where you live in North Dakota, you will receive the very best care from hospitals and healthcare providers committed to using the latest tools and guidelines.

The State of North Dakota has had systems in place for the treatment of acute cardiovascular emergencies since 2013 and for stroke since 2009. These systems were established by the North Dakota legislature and are administered by the North Dakota Department of Health Division of Emergency Medical Systems and partners, including the American Heart Association, critical access hospitals, tertiary hospitals, the North Dakota Emergency Medical Services Association and the North Dakota Department of Health Division of Health Promotion.

Every minute saved in cardiac and stroke emergencies can directly improve survival and recovery rates. The North Dakota cardiac and stroke systems strive to ensure that individuals who suffer a cardiac or stroke emergency in the State of North Dakota receive efficient, streamlined care that minimizes the time between when someone calls 9-1-1 and when the patient receives treatment and supports evidence-based treatment guidelines based upon the current national standards which maximize the patient’s odds for survival and recovery.

North Dakota’s cardiac and stroke systems are supported by the legislature through a small but critical investment of $756,418 over two years. A key component of the system is a funded full-time position within the Department of Health to coordinate the work of the two systems and allowing for the neutral engagement of all system players. In addition, the EMS programs representative leads efforts to work with critical access hospitals to help them meet national standards for hospital designations and to stay engaged as new national guidelines are established.

North Dakota’s hospitals deserve substantial credit for the role they have played in initially supporting cardiac and stroke systems and helping to build them. Through their own capacity development, willingness to share data through registry and designation processes, and assistance with transport planning and the development of treatment algorithms, North Dakota’s hospitals have been an integral partner. The American Heart Association also has worked closely with hospitals and EMS providers across the state to help implement science-based treatment guidelines that help them provide quality care to their patients. This summer, the American Heart Association handed out 18 awards to EMS agencies and hospitals, recognizing them for their commitment to providing excellence in care for heart attack, heart failure, and stroke patients.

The American Heart Association is helping to support the work of the Department of Health, hospitals and EMS agencies across the state by further strengthening the existing stroke system. In June 2017, I had the opportunity to be in North Dakota and join Governor Doug Burgum, State Health Director MyLynn Tufte, and State Representative Todd Porter (coincidentally representing my old district in Mandan, ND) and other state officials, leaders, and AHA volunteers for the announcement of the American Heart Association’s Mission: Lifeline Stroke project. Mission: Lifeline Stroke will build upon the gains achieved in the past 10 years of successful work by the existing North Dakota stroke system by further strengthening the collaboration between hospitals, EMS agencies, the North Dakota Department of Health and other stakeholders. The $5.6 million project is funded through a generous three-year grant of $4.3 million from The Leona M. and Harry B. Helmsley Charitable Trust and additional support from the American Heart Association and in-state partners.

Good, impactful work has been accomplished in North Dakota through the efforts of many champions and players working closely together to maximize the effectiveness of cardiac and stroke systems, helping make North Dakota a model other Midwest states are striving to duplicate. However, all that lifesaving work could be lost through looming fiscal decisions facing the legislature this coming session. I invite you to join with the American Heart Association and other partners across the state in conversations with the Governor’s office and your local and state elected officials. Continued state legislative and fiscal support for this lifesaving work is vital to accomplishing our unified goal: a longer, healthier life for all North Dakotans.

Alvin Royse, J.D., CPA, is a former North Dakota resident and former North Dakota state legislator and is the current immediate past chair of the American Heart Association’s national board of directors. Royse, now of San Francisco, CA, is a retired senior partner with the national accounting firm of Deloitte. Royse is a graduate of the University of North Dakota and also is a past Chairman of the University of North Dakota Foundation and Alumni Foundation.
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Earlier this year, the president signed into law the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act. This bipartisan legislation improves upon the Veterans Choice Program and consolidates all of the Department of Veterans Affairs (VA) community care programs into one, new Veteran Community Care Program. This is all about ensuring our veterans can access convenient and quality health care, both at the VA and through non-federal providers in their local communities. However, it isn’t enough just to pass this bill and sign it into law. We need to ensure this legislation is implemented in the right way so that our veterans can access the care they need and providers who serve them are reimbursed in a timely fashion.

That’s why I have remained in regular contact with individuals in the administration, including recently-confirmed VA Secretary Robert Wilkie, Secretary of Labor Alexander Acosta and Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma, who will all play a key role in ensuring the law is implemented in a smooth and effective manner. I am also working with stakeholders and veterans in North Dakota to guide this law’s implementation, similar to our efforts with the Veterans Care Coordination initiative. We are applying the expertise of our high-quality staff at the Fargo VA and local Veteran Service Organizations to ensure this legislation achieves Congress’ goal of improving veterans’ access to health care and building stronger partnerships with local health care providers.

To this end, I worked to include important measures in the bill to provide veterans with quality health care, closer to home. This includes the main components of my Veterans Access to Long Term Care and Health Services Act, which will expand long-term care (LTC) options for veterans in their home communities and near their loved ones. Currently, only about 20 percent of North Dakota nursing homes contract with the VA due to the agency’s burdensome regulations and reporting requirements. The provisions we secured will allow the VA to enter into provider agreements with qualified health care and long-term care facilities, in lieu of costly federal contracting requirements. At the same time, we’ve advanced this priority through the Senate Appropriations Committee by securing a provision in the Fiscal Year 2019 funding legislation that supports the use of provider agreements between the VA and LTC facilities.

Further, we eliminated the arbitrary 30-day/40-mile rule, which acted as a barrier to veterans receiving care through the Veterans Choice Program. This rule undermined veterans’ ability to access care closer to home and often required them to travel long distances to receive the health care they need. We’ve also expanded caregiver benefits to veterans of all eras. Previously, these benefits were only available to caregivers of post-9/11 veterans, and by opening up eligibility, we are giving the family and friends who care for our veterans the support they deserve.

At the end of the day, the VA MISSION Act is all about empowering veterans to use the health care benefits they have earned, including accessing local providers when nearby VA facilities cannot provide the necessary services. That means a higher quality of life for our veterans, including in their later years when they can rely on LTC services closer to their family and friends. But our work isn’t done. We will continue to strive to ensure this law is properly implemented and that it reforms VA health care in the way that best serves our veterans.
RISING MATERNAL MORTALITY RATES MUST BE URGENTLY ADDRESSED THROUGH BIPARTISAN SOLUTIONS

By Senator Heidi Heitkamp (D-ND)
September 14, 2018

In the twenty-first century, no mother should have to worry about dying during childbirth—especially in a country as advanced as the United States.

But unlike any other industrialized country on Earth, the maternal death rate in the United States is on the rise. According to the U.S. Centers for Disease Control and Prevention, pregnancy-related deaths have increased by 250 percent nationwide from 1987 to 2014. And an alarming 60 percent of these pregnancy and childbirth-related deaths were preventable.

The maternal mortality data we’ve seen over the last few years is particularly concerning for rural or underserved areas, such as across Indian Country. For example, the Urban Indian Health Institute recently released a study showing that American Indian and Alaska Native mothers were 4.5 times more likely to die from pregnancy and childbirth-related causes than non-Hispanic, white mothers.

This trend is absolutely unacceptable, and it’s heartbreaking to read these horrific statistics. Addressing the high rate of deaths due to pregnancy complications must be a national health care priority—and I’m fighting in the U.S. Senate to pass my bipartisan legislation that would lower maternal death rates across the country.

In June, a key U.S. Senate Committee advanced a bill I introduced alongside U.S. Senator Shelley Moore Capito (R-WV) to help examine and combat this growing crisis. Our Maternal Health Accountability Act would strengthen on-the-ground resources to tackle the causes of maternal death by expanding maternal mortality review committees (MMRCs) into additional states. Composed of experts and health care professionals from the fields of maternal, neonatal, and public health, MMRCs examine ways to improve outcomes and spread best practices. MMRCs do not currently exist in 18 states—including North Dakota.

We need to keep working to get our bill across the finish line, so we can continue to find new ways to prevent these tragedies. With additional research into this growing epidemic, our bill would help expecting mothers access critical health care resources like rural hospital facilities, so they can experience healthier pregnancies and stave off life-threatening conditions like preeclampsia.

In short, our legislation would help save lives. By studying and addressing the root causes of pregnancy complications, our bipartisan bill would bolster local and state efforts to increase the number of safe and successful pregnancies in North Dakota. And by expanding access to cutting-edge research and critical information sharing, we’d give physicians and health care providers, like you, the necessary tools to improve the quality of life for mothers and families in our rural communities.

While this legislation would be a vital component of a comprehensive strategy to finally lower maternal mortality rates, Congress must allocate new resources in a fair way to populations in high need of assistance, such as vulnerable mothers on reservations and across rural America. I’ll be pushing to make sure these individuals are not forgotten and receive the assistance they deserve.

But we also can’t take our focus off of the foundation of rural health care—making sure our rural providers can do their jobs effectively with appropriate compensation. As co-chair of the Senate Rural Health Caucus and as the spouse of a family physician, I know that doctors, nurses, and community providers are key components of delivering high-quality, affordable health care to mothers, newborns, and families in our small towns and townships.

Back in February, my bipartisan bill to strengthen rural health care delivery systems passed out of a U.S. Senate committee. Introduced alongside U.S. Senator Pat Roberts (R-KS)—my co-chair on the Senate Rural Health Caucus—our bill would allow State Offices of Rural Health to continue receiving the critical support they need through 2022 to reinforce the rural health workforce and increase affordability of local clinics and hospitals. It recently passed the Senate unanimously, and it accompanies a recently-passed five-year extension of rural Medicare “extenders.”

There is no quick fix to the ballooning maternal mortality crisis facing the nation. But we can start by giving rural providers the tools, research, and support they need to improve health care quality and to reduce health care costs for new and expecting mothers.

And by increasing the number of healthy mothers and babies, we will make our communities stronger and safer places to live, work, and grow.
In the past two sessions of Congress there has been a significant effort to combat the abuse of opioid drugs in the United States, which has reached crisis levels and created a public health emergency. Opioids were first introduced as a non-addictive medication to treat pain, but in the past two decades, their use and abuse have soared. A rise in the illegal manufacturing of synthetic opioids like fentanyl caused a sharp spike in deaths beginning in 2013. Opioid addiction continues to take the lives of more than 100 Americans each and every day.

The House Energy and Commerce Committee, of which I am a member, has taken the lead in the legislative response to this national crisis. We held our first hearing in 2012, and two significant Energy and Commerce Committee initiatives resulted in comprehensive bipartisan legislation signed into law in 2016. The 21st Century Cures Act and Comprehensive Addiction and Recovery Act (CARA) provided resources for combating the epidemic and inter-agency review of best practices for pain management. North Dakota received $4 million in state grants from the 21st Century Cures Act. CARA included legislation which ranged from additional resources to combat the crisis to establishing an inter-agency task force to review, modify, and update best practices for pain management and how it is prescribed.

Additionally, in this Congress, the 2018 Consolidated Appropriations Act (Omnibus) provided $4 billion, the largest investment to date, to help address prevention, treatment, and enforcement issues – including $130 million for the Rural Communities Opioid Response program, striving to reach rural communities that have been hit especially hard by the opioid crisis, and $1 billion in new grants to be dispatched to the states and Indian tribes.

These two laws were a start, but this is a long struggle that will not be quickly solved. Governments, communities, and families must continue to work together. And so, we have come together to advance legislation that will help combat the opioid crisis, which has left a mark on nearly every family across this country. This was affirmed with President Trump’s official declaration of the opioid crisis as a nationwide public health emergency last October and at a White House briefing I attended from top Administration officials in April.

In May and June, the House of Representatives passed more than 50 opioid bills, many of which I co-sponsored. They addressed various aspects of this crisis, including treatment centers, greater education and awareness, pharmacy practices, research on alternative pain management protocols, changes in Medicare and Medicaid coverage and more services to veterans.

Two significant bills are H.R. 6082, the Overdose Prevention and Patient Safety Act, and H.R. 6, the Support for Patients and Communities Act, which passed the house by wide margins in June. H.R. 6082 expands the circumstances under which medical records relating to substance use disorders can be disclosed to healthcare providers, plans, and health care clearing houses, thereby enabling medical professionals to access that information when treating patients. H.R. 6 is a bipartisan bill that will help in our overall efforts to combat the opioid crisis by advancing treatment and recovery initiatives, improving prevention, protecting our communities, and bolstering our efforts to fight deadly illicit synthetic drugs like fentanyl.

The Senate has also responded to the opioid epidemic and passed H.R. 6 as amended September 17. Both the House and Senate are committed to having a final version of this bill for President Trump to sign before the end of the year.

My interest in this legislation has been to ensure treatment and services reach all who need them, including those in rural and underserved areas in North Dakota. Progress is being made, but we have a long struggle ahead to end this crisis. As always, I welcome your feedback on this issue and all others impacting North Dakota hospitals.
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Welcome To An Honest Supply Chain

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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, United Nations Standard Products and Services Code® (UNSPSC).

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.
Three 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

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>
<td>$1,684</td>
</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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The Return on Investment of Assistive Technology

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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